Medicare Claims Processing Manual
Chapter 10 - Home Health Agency Billing

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(Rev. 12106, 06-29-23)
(Rev. 12382, 11-28-23)

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10 - General Guidelines for Processing Home Health Agency (HHA) Claims

(Rev. 2977, Issued; 06-20-14, Effective: 09-23-14; ICD-10: Upon Implementation of ICD-10, Implementation: 09-23-14; ICD-10: Upon Implementation of ICD-10)

This chapter, in general, describes billing and claims processing requirements that are applicable only to home health agencies. For general bill processing requirements refer to the appropriate other chapters in the Medicare Claims Processing Manual. For a description of home health coverage policies see Pub. 100-02, Medicare Benefit Policy Manual, chapter 7.

A. Where and How to Bill

Institutional providers, including home health agencies, use one of two institutional claim formats to bill Original Medicare. In the great majority of cases, these providers are required to use the electronic HIPAA standard institutional claim transaction, the 837 institutional claim. The minority of providers that are eligible for an exception to electronic claim submission use the paper Form CMS-1450, also known as the UB-04. Such claim forms are submitted to certain Medicare Administrative Contractors (A/B MACs (HHH)) with jurisdiction over home health and hospice claims. Some home health agencies may also become approved as Durable Medical Equipment (DME) suppliers, in which case they would submit bills for DMEPOS services to the DME MACs on a professional claim format (the 837professional or paper Form CMS-1500).

References to the claim form in this chapter refer to the paper Form CMS-1450 unless otherwise noted. However, the instructions regarding specific data requirements apply also to the electronic 837 institutional claim.

B. Services to Include on the Claim for Home Health Benefits

Effective for all services provided on or after October 1, 2000, all services under the home health plan of care, except the following, are included in the home health PPS payment amount. Services that may be included in the plan of care but excluded from the HH prospective payment system (HH PPS) are:

- Osteoporosis drugs (although the cost of administration is within the PPS rate); and

- Durable medical equipment, including prosthetics, orthotics, and oxygen

The DMEPOS services may be included on type of bill (TOB) 032x for the home health benefits, and are paid in addition to the PPS payment. See §20 for additional instructions regarding competitively bid DME. Osteoporosis drugs must be billed on type of bill 034x.

Other services not under an HH plan of care provided by an HHA are billed using type of bill 034x. See §90 for guidance as to the payment methodologies used by Medicare to reimburse these services, and see §40.4 in this chapter for information on deductible and coinsurance.

10.1 - Home Health Prospective Payment System (HH PPS)
(Rev. 1, 10-01-03)
HH-467, A3-3639

10.1.1 - Creation of HH PPS and Subsequent Refinements
(Rev. 10758; Issued: 05-11-21; Effective: 01-01-22; Implementation: 08-11-21)

The HH PPS was initially mandated by law in the Balanced Budget Act of 1997 and legislative requirements were modified in various subsequent laws. Section 1895 of the Social Security Act contains current law regarding HH PPS.

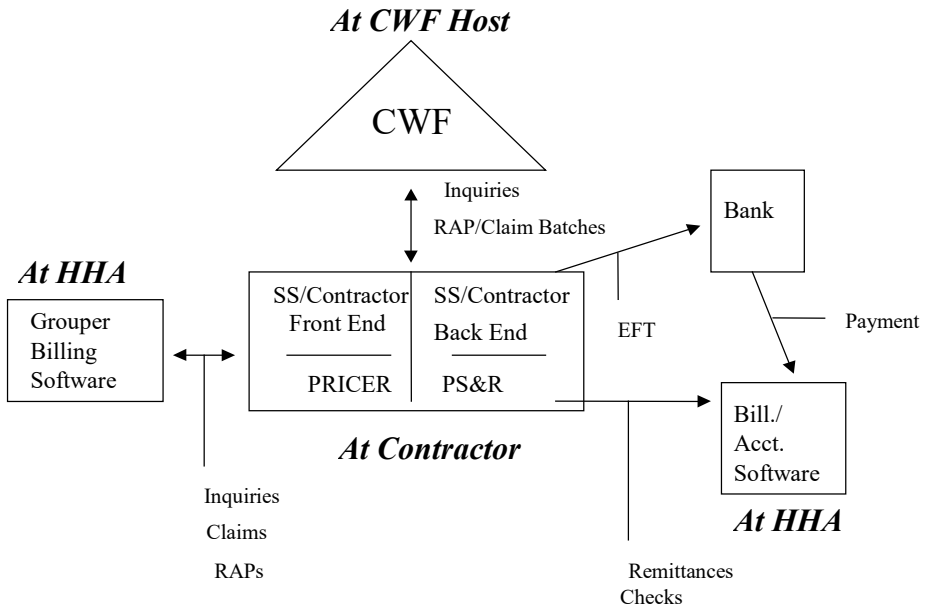
The initial implementation of the HH PPS was effective for dates of service on and after October 1, 2000. Refinements to the case-mix system of the HH PPS system were for episodes of care beginning on and after January 1, 2008. Effective for periods of care beginning on and after January 1, 2020, the original HH PPS system was updated to apply the Patient-Driven Grouping Model. Home health Notices of Admission (NOAs) are required for periods of care beginning on and after January 1, 2022.

The sections that follow describe billing for services on or after January 1, 2022.

10.1.2 - Reserved
(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

10.1.3 - Configuration of the HH PPS Environment
(Rev. 2230, Issued: 05-27-11, Effective: 08-28-11, Implementation: 08-28-11)

The configuration of Medicare home health claim processing is similar to previous Medicare claims processing systems. The flow from the HHA at the start of billing, to the receipt or remittances and electronic funds transfer (EFT) by the agency, to the recording of payment in either billing or accounting systems (bill/acct software) can be envisioned as follows:



Subsystems, also known as drivers or software applications or modules, have been created for HH PPS for Medicare home health claims processing.

- Grouper determines HHRGs for claims at HHAs by inputting OASIS data. (OASIS is the clinical data set that currently must be completed by HHAs for patient assessment.) OASIS software was updated to integrate the Grouper from the advent of HH PPS, and CMS has made Grouper specifications available on its Web site for those designing their own software.

- ELGH is an inquiry system in CWF available via A/B MAC (HHH) remote access, through which HHAs and other providers can ascertain if a home health episode has already been opened for a given beneficiary by another HHA, and track episodes of beneficiaries for whom they are the primary HHA. HHAs may also access this information via the HIPAA Eligibility Transaction System or HETS. Refer to §§30.1 and 30.2 for a detailed description.

Pricer software is used to process all HH PPS claims and is integrated into the Medicare claims processing systems. In addition to pricing HIPPS codes for HHRGs, this software maintains national standard visit rate tables to be used in outlier and LUPA determinations. Refer to §70 for a detailed description of the Pricer software.

10.1.3 - RESERVED

(Rev. 10758; Issued: 05-11-21; Effective: 01-01-22; Implementation: 08-11-21)

10.1.4 - The HH PPS - Unit of Payment

(Rev. 10758; Issued: 05-11-21; Effective: 01-01-22; Implementation: 08-11-21)

The 30-day period of care is the unit of payment for HH PPS. The period of care payment is specific to one individual homebound beneficiary. It pays all Medicare covered home care that is reasonable and necessary for the patient's care, including routine and nonroutine supplies used by that beneficiary during the period of care. It is the only Medicare form of payment for such services, with the exceptions described in §10.B.

See §40 for details on billing these services.

10.1.5 - Number, Duration, and Claims Submission of HH PPS Periods of Care

(Rev. 10758; Issued: 05-11-21; Effective: 01-01-22; Implementation: 08-11-21)

The beneficiary can be covered for an unlimited number of nonoverlapping periods of care. For periods of care beginning on or after January 1, 2020, the duration of a period is 30 days. Periods of care may be shorter than 30 days.

For example, a period may end earlier than the 30th day in the case of a transfer to another HHA, or a discharge and readmission to the same HHA, and payment is pro-rated for these shortened periods, in which more home care is delivered in the same period. Claims for periods may be submitted prior to the 30th day if the beneficiary has been discharged and treatment goals have been met, though payment will not be pro-rated unless more home health care is subsequently billed in the same period.

Other claims for overlapping periods may also be submitted prior to the end of that period if the beneficiary has been discharged, dies or is transferred to another HHA. In transfer cases payment for the period of care will be prorated.

The initial period begins with the first service delivered under that plan of care. A second subsequent period of continuous care would start on the first day after the initial period was completed.

More than one period for a single beneficiary may be opened by the same or different HHAs for different dates of service. This will occur particularly if a transfer to another HHA, or discharge and readmission to the same HHA, situation exists. Refer to §10.1.5.1 below for more information on multiple agencies furnishing home health services. Allowing multiple periods is intended to assure continuity of care and payment.

10.1.5.1 - More Than One Agency Furnished Home Health Services

(Rev. 10758; Issued: 05-11-21; Effective: 01-01-22; Implementation: 08-11-21)

The primary HHA bills for all services furnished by both agencies and keeps all records pertaining to the care and other HHAs serving the same beneficiary. Nonprimary HHAs can receive payment under arrangement only from the primary HHA for services on the plan of care where prior arrangement exists. The primary agency's status as primary is

established through the submission, receipt and processing of a Notice of Admission (NOA) for the home health care for the beneficiary. The secondary agency is paid through the primary agency under mutually agreed upon arrangements between the two agencies existing before the delivery of services for services called for under the plan of care.

Two agencies must never bill as primary for the same beneficiary for the same admission period. When the Common Working File (CWF) indicates an admission period is open for a beneficiary, the A/B MAC (HHH) returns to the provider the NOA of any other agency billing unless the NOA indicates a transfer or discharge and readmission situation exists.

In rare cases, a Medicare beneficiary may receive an organ transplant and the organ donor's post-operative services are covered by the Medicare program. Since the donor is frequently not a Medicare beneficiary, services for the donor are billed using the Medicare beneficiary's Medicare number. If both the organ recipient and organ donor are receiving post-operative home health services, CWF cannot process HH PPS periods for both patients for the same dates of service. In this case, the HH claim for the organ recipient is accepted by CWF. The HH claim for the donor is processed by the A/B MAC (HHH) outside CWF.

10.1.5.2 - Effect of Election of Medicare Advantage (MA) Organization and Eligibility Changes on HH PPS

(Rev. 10758; Issued: 05-11-21; Effective: 01-01-22; Implementation: 08-11-21)

If a Medicare beneficiary is covered under an MA organization during a period of home care, and subsequently decides to change to Medicare fee-for-service coverage, a new OASIS assessment must be completed, as is required any time the Medicare payment source changes. With that assessment, an NOA may be sent to Medicare to open an HH PPS period.

If a beneficiary under fee-for-service receiving home care elects an MA organization during an HH PPS period of care, the period will end and be proportionally paid according to its shortened length (a partial period payment adjustment). The MA organization becomes the primary payer upon the MA organization enrollment date.

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10.1.6 - RESERVED

(Rev. 10758; Issued: 05-11-21; Effective: 01-01-22; Implementation: 08-11-21)

10.1.7 - Basis of Medicare Prospective Payment Systems and Case-Mix

(Rev. 10758; Issued: 05-11-21; Effective: 01-01-22; Implementation: 08-11-21)

There are multiple prospective payment systems (PPS) for Medicare for different provider types. Before 1997, prospective payment was a term specifically applied to inpatient hospital services. In 1997, with passage of the Balanced Budget Act, prospective payment systems were mandated for other provider groups/bill types:

- Skilled nursing facilities;
- Outpatient hospital services;
- Home health agencies;
- Rehabilitation hospitals; and
- Others.

While there are commonalities among these systems, there are also variations in how each system operates and in the payment units for these systems.

Case-mix is an underlying concept in prospective payment. With the creation of inpatient hospital PPS, the first Medicare PPS, there was a recognition that the differing characteristics of hospitals, such as teaching status or number of beds, contributed to substantial cost differences, but that even more cost impact was linked to the characteristics of the patient populations of the hospitals. Other Medicare PPS systems, where research is applied to adjust payments for patients requiring more complex or costly care, use this concept of case-mix complexity, meaning that patient characteristics affect the complexity, and therefore, cost of care. HH PPS considers a patient's clinical and functional condition in determining case-mix for home health care.

For individual Medicare inpatient acute care hospital bills, diagnosis related groups (DRGs) are produced by claim information, which includes data elements such as procedure and diagnoses, through Grouper software that reads these pertinent elements on the claim and groups services into appropriate DRGs. DRGs are then priced by a separate Pricer software module at the A/B MAC (A). Processing for HH PPS is built on this model, using home health resources groups (HHRGs), instead of DRGs. In HH PPS, payments are case-mix adjusted using claim information and elements of the patient assessment.

Since 1999, HHAs have been required by Medicare to assess potential patients, and reassess existing patients, incorporating the OASIS (Outcome and Assessment Information Set) tool as part of the assessment process. The total case-mix adjusted payment is based on elements of the OASIS data set and other information provided on the claim. Payments made for the period are case-mix adjusted based on Grouper run in Medicare systems. Pricer software run by the A/B MAC (HHH) processing home health claims performs pricing including wage index adjustment and other factors.

10.1.8 - Coding of HH PPS Case-Mix Groups on HH PPS Claims: HHRGs and HIPPS Codes

(Rev. 10758; Issued: 05-11-21; Effective: 01-01-22; Implementation: 08-11-21)

Under the home health prospective payment system as refined by the Patient-Driven Groupings Model, a case-mix adjusted payment for a 30-day period of care is made using one of 432 HHRGs. On Medicare claims, these HHRGs are represented as Health Insurance Prospective Payment System (HIPPS) codes.

HIPPS code rates represent specific characteristics (or case-mix) on which Medicare payment determinations are made. HIPPS codes are used in association with special revenue codes used on institutional claims submitted to A/B MACs (HHH). One revenue code is defined for every Medicare prospective payment system that uses HIPPS codes. For home health claims, this is revenue code 0023. HIPPS codes are placed in HCPCS/Accommodation Rates/HIPPS Rate Codes field of the claim.

10.1.9 - Composition of HIPPS Codes for HH PPS

(Rev. 10758; Issued: 05-11-21; Effective: 01-01-22; Implementation: 08-11-21)

For HH PPS periods of care, the distinct 5-position, alphanumeric home health HIPPS codes are created as follows:

- The first position represents a combination of the referral source (community or institutional) and the period timing (early or late).
- The second and third positions represent the clinical and functional domains of the HHRG coding system.
- The fourth position represents the co-morbidity category that applies to the patient.
- The fifth position is a placeholder for future use, required only because the field used to report HIPPS codes requires five positions.

Position #1	**Position #2**	**Position #3**	**Position #4**	**Position #5**
Source & Timing	**Clinical Group**	**Functional Level**	**Co-Morbidity**	**Placeholder**
1 - Community Early	**A -** MMTA Other	**A -** Low	**1 -** None	**1**
2 - Institutional Early	**B -** Neuro Rehab	**B -** Medium	**2 -** Low	
3 - Community Late	**C -** Wounds	**C -** High	**3 -** High	
4 - Institutional Late	**D -** Complex Nursing Interv.			

Position #1	Position #2	Position #3	Position #4	Position #5
Source & Timing	**Clinical Group**	**Functional Level**	**Co-Morbidity**	**Placeholder**
	E - MS Rehab			
	F – Behavioral Health			
	G – MMTA Surgical Aftercare			
	H – MMTA Cardiac & Circulatory			
	I – MMTA Endocrine			
	J – MMTA GI/GU			
	K – MMTA Infectious Disease			
	L – MMTA Respiratory			

Using this structure, a second period for a patient with a hospital inpatient stay during the period, in the Wounds group, high functional severity and no co-morbidity would be coded 4CC11.

HIPPS codes created using this structure are valid only on claim lines with revenue code 0023.

10.1.10 - Provider Billing Process Under HH PPS

(Rev. 1, 10-01-03)
HH-467.15, A3-3639.15

The next four sections describe the basic HH PPS billing process, not including payment adjustments. Payment adjustment follows in subsequent sections.

10.1.10.1 - Grouper Links Assessment and Payment

(Rev. 10758; Issued: 05-11-21; Effective: 01-01-22; Implementation: 08-11-21)

The home health Grouper software is incorporated in Medicare claims processing systems. The Grouper uses claims data and OASIS data from the CMS quality data repository to assign the HIPPS code used for payment on the claim.

In the event of a temporary failure of the file transfer process that connects the claims and quality data systems, the MACs may resubmit claims to the quality system to ensure matching OASIS data is found. This action may occur in response to notification from CMS or at the discretion of the MAC.

10.1.10.2 - Reserved

(Rev. 10758; Issued: 05-11-21; Effective: 01-01-22; Implementation: 08-11-21)

10.1.10.3 - Submission of the Notice of Admission (NOA)

(Rev. 12106; Issued: 06-29-23, Effective: 01- 01-24; Implementation:01-02-24)

For each admission to home health, the HHA notifies Medicare systems via submission of a *Notice of Admission (*NOA*)*.

HHAs shall send the NOA to the A/B MAC (HHH) by mail, electronic data interchange (EDI), or direct data entry (DDE). EDI submissions require additional data not required by the NOA itself, to satisfy transaction standards. This data is described in a companion guide available on the CMS website. HHAs may voluntarily agree to adopt the companion guide and use it to submit EDI NOAs at any time.

The HHA can submit an NOA to Medicare when:

- The HHA has obtained a verbal or written order from the physician that contains the services required for the initial visit, and
- The HHA has conducted an initial visit at the start of care.

Only one NOA is required for any series of HH periods of care beginning with admission to home care and ending with discharge. After a discharge has been reported to Medicare, a new NOA is required before the HHA submits any additional claims.

NOAs must be submitted timely. A timely-filed NOA is submitted to and accepted by the A/B MAC (HHH) within five calendar days after admission date.

In instances where an NOA is not timely-filed, Medicare shall reduce the payment for a period of care, including outlier payment, by the number of days from the home health admission date to the date the NOA is submitted to, and accepted by, the A/B MAC (HHH), divided by 30. No LUPA per-visit payments shall be made for visits that occurred on days that fall within the period of care prior to the submission of the NOA. This reduction shall be a provider liability, and the provider shall not bill the beneficiary for it.

If an HHA fails to file a timely-filed NOA, it may request an exception, which, if approved, waives the consequences of late filing. The four circumstances that may qualify the HHA for an exception are as follows:

1. fires, floods, earthquakes, or other unusual events that inflict extensive damage to the HHA's ability to operate;

2. an event that produces a data filing problem due to a CMS or A/B MAC (HHH) systems issue that is beyond the control of the HHA;

3. a newly Medicare-certified HHA that is notified of that certification after the Medicare certification date, or which is awaiting its user ID from its A/B MAC (HHH); or,

4. other circumstances determined by the A/B MAC (HHH) or CMS to be beyond the control of the HHA.

When an NOA is submitted within the five day timely filing period, but the NOA contains inadvertent errors (such as a beneficiary identifier that has recently changed), the error may not trigger the NOA to be immediately returned to the HHA for correction. In these instances, the HHA must wait until the incorrect information is fully processed by Medicare systems before the NOA is returned for correction. Such delays in Medicare systems could cause the NOA to be late. Delays due to Medicare system constraints are outside the control of the HHA and may qualify for an exception to the timely filing requirement.

HHAs can reduce the number of errors and exception requests related changes to the beneficiary identifier by performing an eligibility check immediately before admission. This can confirm that the Medicare Beneficiary Identifier (MBI) is active and accurate since the eligibility inquiry system contains an MBI End Date field. If there is a date in that field, the MBI is not valid after that date. The HHA can contact the beneficiary or use the MBI Lookup tool to determine the current MBI to use on the NOA.

Since correct beneficiary identifier information is available to the HHA, only changes that occur shortly before the admission are beyond the HHA's control. A/B MAC (HHH) MACs will not grant exceptions based on MBI changes that were accessible to the HHA more than two weeks prior to the admission date.

An admission period will be opened on CWF with the receipt and processing of the NOA. NOAs are submitted using TOB 032A. After this admission period is recorded, the HHA can submit claims for HH periods of care in the admission.

See section 40.1 for detailed submission instructions and required information for the NOA.

10.1.10.4 - Claim Submission and Processing

(Rev. 10758; Issued: 05-11-21; Effective: 01-01-22; Implementation: 08-11-21)

Payment due to an HHA for a period of care will be made based on a claim submitted at the end of the 30-day period, or after the patient is discharged, whichever is earlier. HHAs may not submit this claim until after all services are provided for the period and the physician has signed the plan of care and any subsequent verbal order.

All HH PPS claims must be submitted with TOB 0329. The HH PPS claim will include line item detail describing all the services provided in the period of care. At a provider's option, any durable medical equipment, oxygen or prosthetics, and orthotics provided may also be billed on the HH PPS claim, and this equipment will be paid in addition to the period of care payment.

However, osteoporosis drugs and disposable negative pressure wound therapy (dNWPT) services must be billed separately on TOB 034x claims, even when an admission period is open. See section 90.

Claims for periods of care may span calendar and fiscal years. Payment rates are determined for all services on the claim using the Statement Covers Period "Through" date on the claim.

Once the payment for a period of care is calculated, Medicare claims processing systems determine whether the claim should be paid from the Medicare Part A or Part B trust fund. This A-B shift determination does not affect HHA payment amounts. Informational value codes for A and B visits (value codes 62 and 63) and dollar amounts (64 and 65) may be visible to HHAs on electronic claim remittance records, but providers do not submit these value codes.

10.1.11 - Payment, Claim Adjustments and Cancellations

(Rev. 10758; Issued: 05-11-21; Effective: 01-01-22; Implementation: 08-11-21)

HHAs may cancel or adjust claims. Type of bill 0328 is used to cancel an HH PPS claim. A cancellation is needed to change the beneficiary identifier or the HHA's provider number, if originally submitted incorrectly. Type of bill 0327 is used to adjust an HH PPS claim. Adjustments are used to correct information that may change payment.

10.1.12 - RESERVED

(Rev. 10758; Issued: 05-11-21; Effective: 01-01-22; Implementation: 08-11-21)

10.1.13 - Transfer Situation - Payment Effects

(Rev. 10758; Issued: 05-11-21; Effective: 01-01-22; Implementation: 08-11-21)

By law under the HH PPS system, beneficiaries must be able to transfer among HHAs, and payments must be pro-rated to reflect these changes. To accommodate this requirement, HHAs submit an NOA with condition code 47 to indicate a transfer when an admission period may already be open for the same beneficiary at another HHA.

In order for a receiving HHA to accept a beneficiary elected transfer, the receiving HHA must document that the beneficiary has been informed that the initial HHA will no longer receive Medicare payment on behalf of the patient and will no longer provide Medicare covered services to the patient after the date of the patient's elected transfer in accordance with current patient rights requirements at 42 CFR 484.10(e). Documentation of these notifications may be needed if the transfer is disputed and verification is required as described in the Medicare Benefit Policy Manual, chapter 7, section 10.8.E. The receiving HHA must also document in its records that it accessed a Medicare inquiry system to determine whether or not the patient was under an established home health plan of care and contacted the initial HHA on the effective date of transfer.

In such cases, the previously open admission period will be automatically closed in Medicare claims processing systems as of the date services began at the HHA the beneficiary transferred to, as reported in the NOA. The new admission period for the "transfer to" agency will begin on that same date. Payment will be pro-rated for the last claim in the closed admission period of the "transferred from" agency.

10.1.14 - Discharge and Readmission Situation Under HH PPS - Payment Effects

(Rev. 10758; Issued: 05-11-21; Effective: 01-01-22; Implementation: 08-11-21)

Under HH PPS, HHAs may discharge beneficiaries before the period of care has closed if all treatment goals of the plan of care have been met. Cases may occur in which an HHA has discharged a beneficiary during a period of care, but the beneficiary is readmitted to the same agency in the same 30 days. Since no portion of the period can be paid twice, the first payment must be pro-rated to reflect the shortened period (see §10.1.15). A new admission period can be opened by the HHA. Medicare systems will allow this in cases where the CMS certification number (CCN) on the new NOA matches the CCN on the prior period. The next period of care will begin the date the first service is supplied under readmission (setting a new 30-day "clock").

Note that beneficiaries do not have to be discharged within the period because of admissions to other types of health care providers (i.e., hospitals, skilled nursing facilities), but HHAs may choose to discharge in such cases. If an agency chooses not to discharge and the patient returns to the agency in the same 30-day period, the same period of care continues. However, if an agency chooses to discharge, based on an expectation that the beneficiary will not return, the agency should recognize that if the beneficiary does return to them in the same period, the discharge is not recognized for Medicare payment purposes. All the HH services provided in the complete period of care, both before and after the inpatient stay, should be billed on one claim. When discharging, full payment would still be made unless the beneficiary received more home care later in the same period.

Discharge is not required if the beneficiary has an inpatient stay that spans the end of the first 30-day period of care in a 60-day certification period. The HHA should submit the

claim for the period following the discharge as if the 30-day periods were contiguous – submit a From date of day 31, even though it falls during the inpatient stay and the first visit date that occurs after the hospital discharge. Medicare systems will allow the HH claim to overlap the inpatient claim for dates in which there are no HH visits.

10.1.15 - Payment Adjustments - Partial Period Payment Adjustment

(Rev. 10758; Issued: 05-11-21; Effective: 01-01-22; Implementation: 08-11-21)

Both transfer situations and discharge and readmission to the same agency in a 30-day period result in shortened periods of care. In such cases, payment will be pro-rated.

Partial period payment adjustments occur as a result of the two following situations:

a. When a patient has been discharged and readmitted to home care within the same 30-day period of care; or

b. When a patient transfers to another HHA during a 30-day period of care.

Both situations are indicated on the claim by reporting a Patient Discharge Status code of 06. Based on the presence of this code, Pricer calculates a partial period payment adjustment to the claim. This is a proportional payment amount based on the number of days of service provided, which is the total number of days counted from and including the day of the first billable service to and including the day of the last billable service, divided by 30.

The contractor shall use the following remittance advice messages and associated codes when paying partial period payment adjustments under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO
CARC: B20
RARC: N120
MSN: N/A

10.1.16 - Payment When Death Occurs During an HH PPS Episode/Period

(Rev. 10758; Issued: 05-11-21; Effective: 01-01-22; Implementation: 08-11-21)

If a beneficiary dies during a period of care, full payment will be made for the period, including payment adjustments applicable to given services actually delivered prior to death. However, there is one exception. Partial period payment adjustments will not apply to the claim, because no more home care can be delivered in the 30-day period. The Statement Covers Period “through” date on the claim in which the beneficiary died should be the date of death. Such claims may be submitted earlier than the 30th day of the period of care.

10.1.17 - Payment Adjustments - Low Utilization Payment Adjustments (LUPAs)

(Rev. 10919, Issued:08-06-21, Effective:01-01-22, Implementation: 01-03-22)

If an HHA provides fewer than the threshold of visits specified for the period's HHRG, they will be paid a standardized per visit payment. Such payment adjustments are called Low Utilization Payment Adjustments (LUPAs).
On LUPA claims, nonroutine supplies will not be reimbursed in addition to the visit payments, since total annual supply payments are factored into all payment rates. If the claim for the LUPA is later adjusted such that the number of visits is equal to or greater than the threshold for the HHRG, payments will be adjusted to an HHRG basis, rather than a visit basis.

If the LUPA period is the first in a sequence of adjacent periods or is the only period of care the beneficiary received, Medicare will make an additional add-on payment. Medicare will add to these claims an amount calculated from a factor established in regulation. This additional payment will be reflected in the payment for the earliest dated revenue code line representing a home health visit for skilled nursing, physical therapy, occupational therapy (after January 1, 2022), or speech-language pathology.

One criterion that Medicare uses to determine whether a LUPA add-on payment applies is that the claim Admission Date matches the claim "From" Date. HHAs should take care to ensure that they submit accurate admission dates, especially if claims are submitted out of sequence. Inaccurate admission dates may result in Medicare systems returning LUPA claims where an add-on payment applies, but the add-on was paid inappropriately on a later dated period in the same sequence.

Additionally, Medicare systems may return to the provider LUPA claims if the claim meets the criteria for a LUPA add-on payment but it contains no qualifying skilled service. In these cases, the HHA may add the skilled visit to the claim if it was omitted in error and re-submit the claim. Otherwise, the HHA may only re-submit the claim using condition code 21, indicating a billing for a denial notice.

10.1.18 – RESERVED

10.1.19 - Payment Adjustments – Applying OASIS Assessment Items to Determine HIPPS Codes

(Rev. 12106; Issued: 06-29-23, Effective: 01- 01-24; Implementation: 01-02-24)

Submission of an OASIS assessment is a condition of payment for HH periods of care. OASIS reporting regulations require the OASIS to be transmitted within 30 days of completing the assessment of the beneficiary. Under the HH PDGM, matching a claim to the OASIS assessment *is required to process each home health claim.*
During claims processing, the quality system, known as the Internet Quality Improvement and Evaluation System (iQIES), provides the claims system (FISS), with the OASIS items used for payment grouping under the PDGM. The HIPPS code is

calculated by Medicare's Grouper program with FISS. Because payment grouping cannot occur without the OASIS information, if the OASIS assessment is not found in the quality system upon receipt of a claim, Medicare systems will return the HH claim. *The only exception to this is when a disaster-related waiver of OASIS submission is in effect. In this case, the HHA reports condition code DR on the claim and does not report occurrence 50 (the assessment submission date) because no OASIS was submitted. The claim-OASIS matching process is bypassed and the provider-submitted HIPPS code is used for payment. In any other case, when occurrence code 50 is reported a matching assessment must be found in order for the claim to process.*
There are steps an HHA can take to make sure a claim matches to the OASIS assessment successfully.

Ensuring the Claim Matches an OASIS Assessment

Before submitting an HH claim, HHAs should ensure the OASIS assessment has completed processing and was successfully accepted into iQIES. HHAs can verify this by reviewing their OASIS Final Validation Report (FVR).

If a claim is submitted and Medicare systems do not find the matching assessment, the claim is Returned to the Provider (RTP). Typically, there is no need to call the iQIES help desk for assistance in resolving this.

HHAs should take the following steps:

1. Double-check the FVR to confirm the receipt date shows the OASIS was accepted by iQIES before you submitted your claim. This date is shown on Page 1 of the report, in the field labeled, "Completion Date/Time." Also, ensure that the assessment has not been inactivated.
   - If the OASIS was submitted after the claim, resubmit the claim
   - If the assessment was inactivated, resubmit the assessment.

2. Ensure the assessment is one that is used for determining payments. The Reason for Assessment (RFA) (OASIS Item M0100) must be equal to 01, 03, 04, or 05.
   - If the claim matches an assessment that is for another reason, update the occurrence code 50 date on the claim to correspond to the M0090 date of the applicable assessment and resubmit the claim.

3. Ensure you have submitted occurrence code 50 on any claims, reporting the assessment completion date (item M0090) as the associated date
   - If the occurrence code is missing, update the claim and resubmit it.

4. Check the items Medicare systems use to match the claim and OASIS, making sure that they are the same on both submissions. These are:
   - Your CMS Certification Number (OASIS item M0010)
   - Beneficiary Medicare Number (OASIS item M0063)
   - Assessment Completion Date (OASIS item M0090)

If any of these items do not match, correct the claim or the assessment, then resubmit.

Note: Changes to a beneficiary's Medicare Beneficiary Identifier (MBI) can affect the match. If an HHA becomes aware of a change to the MBI via the MBI look-up tool and uses the new MBI on their claim when the prior MBI was used on the OASIS, that will cause the claim to be returned. In these cases, HHAs should update item M0063 on the OASIS and then resubmit the claim.

If a claim with correct and matching information continues to RTP, the HHA should reach out to their MAC and provide:

- The claim document control number (DCN)
- The validation report's Page 1, showing the Completion Date/Time the batch of OASIS assessments was received
- The validation report's page for the OASIS assessment in question, showing the RFA, Medicare Number, and M0090 date
- Any other information requested by the MAC to confirm the matching OASIS

The MAC shall use this information to research the issue.

<u>When a Matching OASIS is Found</u>

When the OASIS assessment if found, answers to the OASIS items used in PDGM case-mix scoring are returned to the claims system and stored on the claim record. This information is displayed on a screen in the claims system, so the HHA can refer to it. Medicare systems combine OASIS items and claims data (period timing, inpatient discharge, diagnoses) and send them to HH Grouper program (see section 80). The Grouper-produced HIPPS code replaces the provider-submitted HIPPS code on the claim and is used for payment.

The system-calculated HIPPS code may be re-coded by medical reviewers, based on their review of the documentation supporting the claim. In this case, the medical reviewer indicates changes to the OASIS information on the claim screen where it is displayed. The original OASIS item information is in a column marked OA, the medical reviewers changes are recorded in a column marked MR. The revised OASIS information will be sent to the HH Grouper and a new HIPPS will be used for payment. This HIPPS code will be recorded in the APC-HIPPS field. This code will match the code on the electronic remittance advice.

<u>When an OASIS Assessment Has Not Been Submitted</u>

If there was no error and the condition of payment was not met, the HHA may bill for denial using the following coding:

- Type of Bill (TOB) 0320 indicating the expectation of a full denial for the billing period,
- Occurrence span code 77 with span dates matching the From/Through dates of the claim, indicating the HHA's acknowledgment of liability for the billing period, and

- Condition code D2, indicating that billing for the Health Insurance Prospective Payment System (HIPPS) code is changed to non-covered.

Condition code 21 must not be used in these instances, since it would result in inappropriate beneficiary liability.

The contractor shall use the following remittance advice messages and associated codes when processing billings for denial under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO
CARC: 272
RARC: N211
MSN: 41.17

10.1.20 - RESERVED

(Rev. 2230, Issued: 05-27-11, Effective: 08-28-11, Implementation: 08-28-11)

10.1.21 - Payment Adjustments - Outlier Payments

(Rev. 10758; Issued: 05-11-21; Effective: 01-01-22; Implementation: 08-11-21)

HH PPS payment groups are based on averages of home care experience. When cases "lie outside" expected experience by involving an unusually high level of services in 30-day periods of care, Medicare claims processing systems will provide outlier payments in addition to the case-mix adjusted payment. Outlier payments can result from medically necessary high utilization in any or all of the service disciplines.

Outlier determinations are made by comparing:

- The estimated cost for a period of care, calculated as the sum of the products of number of units of each discipline on the claim and each wage-adjusted national standardized per unit rate for each discipline (1 unit = 15 minutes); with

- The sum of the period payment and a wage-adjusted standard fixed loss threshold amount.

If the estimated cost is greater than the wage adjusted and case-mix specific payment amount plus the wage adjusted fixed loss threshold amount, a set percentage (the loss sharing ratio) of the amount by which the estimated cost exceeds the sum will be paid to the HHA as an outlier payment. Units considered for outlier payment are subject to a limit of 32 units (8 hours), summed across the six disciplines of care, per date of service.

For rare instances when more than one discipline of care is provided and there is more than 8 hours of care provided in 1 day, the cost associated with the care provided during that day will be calculated using a hierarchical method based on the cost per unit per discipline. The discipline of care with the lowest associated cost per unit will be

discounted in the calculation of cost in order to cap the estimation of cost at 8 hours of care, summed across the six disciplines, per day.

The outlier payment is a payment for an entire period, and therefore carried only at the claim level on the paid claim. It is not allocated to specific lines of the claim.

HHAs do not submit anything on their claims to be eligible for outlier consideration. The outlier payment shall be included in the total payment for the claim on a remittance, but it will be identified separately on the claim using value code 17 with an associated dollar amount representing the outlier payment. Outlier payments will also appear on the electronic remittance advice in a separate segment.

Outlier payments made to each HHA are subject to an annual limitation. Medicare systems ensure that outlier payments comprise no more than 10 percent of the HHA's total HH PPS payments for the year. Medicare systems track both the total amount of HH PPS payments that each HHA has received and the total amount of outlier payments that each HHA has received. When each HH PPS claim is processed, Medicare systems compare these two amounts and determine whether the 10 percent has currently been met.

If the limitation has not yet been met, any outlier amount is paid normally. If the limitation has been met or would be exceeded by the outlier amount calculated for the current claim, other HH PPS amounts for the claim are paid but any outlier amount is not paid. Partial outlier payments are not made.

The contractor shall use the following remittance advice messages and associated codes when not paying outlier amounts under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Three.

Group Code: CO
CARC: 119
RARC: N/A
MSN: N/A

Since the payment of subsequent claims may change whether an HHA has exceeded the limitation over the course of the timely filing period, Medicare systems conduct a quarterly reconciliation process. All claims where an outlier amount was calculated but not paid when the claim was initially processed shall be reprocessed to determine whether the outlier has become payable. If the outlier can be paid, the claim is adjusted to increase the payment by the outlier amount. Additionally, if any HHAs are found to have been overpaid outlier during the quarterly reconciliation process, claims are adjusted to recover any excess payments.

These adjustments appear on the HHA's remittance advice with a type of bill code that indicates a contractor-initiated adjustment (TOB 032I) and the coding that typically

identifies outlier payments. This quarterly reconciliation process occurs four times per year, in February, May, August and November.

10.1.22 - RESERVED

(Rev. 10758; Issued: 05-11-21; Effective: 01-01-22; Implementation: 08-11-21)

10.1.23 - Changes in a Beneficiary's Payment Source

(Rev. 10758; Issued: 05-11-21; Effective: 01-01-22; Implementation: 08-11-21)

1. Payment Source Changes From Medicare Advantage (MA) Organization to Original Medicare.

If a Medicare beneficiary is covered under an MA Organization during a period of home care, and subsequently decides to change to Original Medicare coverage, a new start of care OASIS assessment must be completed that reflects the date of the beneficiary's change to this pay source. This is required any time the payment source changes to Original Medicare. With that assessment, an NOA may be sent to Medicare to open an HH PPS admission period. HHAs are advised to verify the patient's payer source on a regular basis when providing services to a patient with an MA Organization payer source to avoid the circumstance of not having an OASIS to be used to determine the payment group, or having the patient discharged without an OASIS assessment.

If a follow-up assessment is used to generate a new start of care assessment, CMS highly recommends, but does not require, a discharge OASIS assessment be done.

While this is not a requirement, conducting a "paper" discharge at the point where the patient's change in insurance coverage occurred will provide a clear endpoint to the patient's episode of care for purposes of the individual HHA's outcome-based quality reports. Otherwise, that patient will not be included in the HHA's quality measure statistics. It will also keep that patient from appearing on the HHA's roster report (a report the HHAs can access from the OASIS system that is helpful for tracking OASIS start of care and follow-up transmissions) when the patient is no longer subject to OASIS data collection.

In cases where the patient changes from MA coverage to Original Medicare coverage, the patient's overall Medicare coverage is uninterrupted. This means an HH PPS period of care may be billed beginning on the date of the patient's Original Medicare coverage. Upon learning of the change in MA election, the HHA should submit an NOA using the date of the first visit provided after the Original Medicare effective date as the "from" date. The OASIS assessment performed most recently after the change in election is used to produce a HIPPS code for the first claim in the new admission period.

If a new start of care (SOC) OASIS assessment was not conducted at the time of the change in pay source, a correction to an existing OASIS assessment may be necessary to change the reported payer source. The HHA should correct the existing OASIS

assessment conducted most closely after the new start date. If more than one 30-day period has elapsed before the HHA learns of the change in payer source, this procedure can be applied to the additional periods. If the patient is still receiving services, the HHA must complete the routine follow-up OASIS assessments (RFA4) consistent with the new start of care date. In some cases, HHAs may need to inactivate previously transmitted assessments to reconcile the data collections with the new dates.

2. Payment Source Changes From Original Medicare to MA Organization

In cases where the patient elects MA coverage during an HH PPS period of care, the period will end and be proportionally paid according its shortened length (a partial period payment adjustment). The MA Organization becomes the primary payer upon the MA enrollment date. The HHA may learn of the change after the fact, for instance, upon rejection of their claim by Medicare claims processing systems. The HHA must resubmit this claim indicating a transfer of payer source using patient status code "06," and reporting only the visits provided under the fee-for-service eligibility period. The claim through date and the last billable service must occur before the MA enrollment date. If the patient has elected to move from Original Medicare to an MA Organization and is still receiving skilled services, the HHA should indicate the change in payer source on the OASIS at the next assessment time point.

3. Payment Source Changes Involving Medicaid

There may be cases where a patient eligible for both Medicare and Medicaid is receiving home health services covered under Medicaid and the patient experiences a change in status that allows their home health services to meet coverage criteria for Original Medicare. In these cases, a new start of care OASIS assessment must be completed that reflects the date of the beneficiary's change to this pay source. This is required any time the payment source changes to Original Medicare. With that assessment, an NOA may be sent to Medicare to open an HH PPS admission period. The OASIS guidance provided above for changes from Medicare Advantage to Original Medicare apply in this case also.

If a patient eligible for both Medicare and Medicaid is receiving home health services covered under Medicare and ceases to meet Medicare coverage criteria, the patient should be discharged for Medicare purposes. Patient status code "06" should not be used. This discharge has no payment impact on the Medicare HH PPS period. If the patient being discharged to Medicaid-only coverage is still receiving skilled services, the HHA should indicate the change in payer source on the OASIS at the next assessment.

10.1.24 - Glossary and Acronym List

(Rev. 10758; Issued: 05-11-21; Effective: 01-01-22; Implementation: 08-11-21)

ABN - Advance Beneficiary Notice of Non-Coverage

Admission Date - For HH PPS, the date of the first service delivered by the HHA in a period of care or a series of continuous periods. It is placed in the Admission/Start of Care Date field on the institutional claim.

Admission Period – The period between the From date of a Notice of Admission and the discharge date. An admission period may contain several 30-day periods of care and their corresponding claims.

A/B MAC (A) - A/B MACs processing hospital claims.

A/B MAC (HHH) - A/B MACs processing all Home Health and Hospice claims.

CBSA - Core Based Statistical Area

CCN - CMS certification number

Claim - The transaction submitted to receive payment for an HH PPS 30-day period of care.

CLIA - Clinical Laboratory Improvement Amendments

CMS - The Center for Medicare & Medicaid Services, the Federal Agency administering the Medicare program.

CWF - Common Working File

DCN - Document Control Number

DME - Durable Medical Equipment.

DME MAC - DME Medicare Administrative Contractor - 4 Medicare contractors nationally processing DME on professional claim formats.

DMEPOS - Durable Medical Equipment, Prosthetics, Orthotics and Supplies.

DOEBA - Date of Earliest Billing Activity

DOLBA - Date of Latest Billing Activity

Grouper - A software module that uses claim and assessment information for payment classification. For HH PPS, this data is grouped to determine HHRGs and corresponding HIPPS codes.

HCPCS Code(s) - Healthcare Common Procedure Coding System. Coding for services or items used in the HCPCS/Accommodation Rates/HIPPS Rate Codes field on institutional claim formats.

HH - Home Health

HHA(s) - Home Health Agency(ies)

HH PPS - Home Health Prospective Payment System

HHRG - Home Health Resource Group. One of the case-mix groups that determine HH PPS payment rates.

HIPAA - Health Insurance Portability and Accountability Act

HIPPS - Health Insurance Prospective Payment System. Coding used in the HCPCS/ Accommodation Rates/HIPPS Rate Codes field on institutional claim formats to represent case-mix groups in certain prospective payment systems.

ICD - International Classification of Diseases

LUPA - Low Utilization Payment Adjustment.

MAC - Medicare Administrative Contractor, one of the contractors processing Medicare claims.

National Standard Per Visit Rates - National rates for each of the 6 home health disciplines based on historical claims data. These rates are used in payment of LUPAs.

NOA – Notice of Admission

NUBC - National Uniform Billing Committee

OASIS - Outcome and Assessment Information Set. The HH patient assessment instrument.

Outlier - An addition to payment in cases where costs of services delivered are estimated to exceed a fixed loss threshold.

PPS - Prospective Payment System. Medicare payment for medical care based on pre-determined payment rates or periods, linked to the anticipated intensity of services delivered and/or beneficiary condition.

Pricer - Software modules in Medicare claims processing systems used to calculate payments under prospective payment systems.

RA - Remittance Advice

Revenue Code - Four position payment codes for services or items placed in the Revenue Codes field on institutional claim formats. An “x” in the last digit of revenue codes means that value can vary from 0-9.

TOB - Type of Bill (e.g., 032x, 034x). Coding representing the nature of each institutional claim (i.e., type of provider, such as home health; frequency of bill) - an “x” in the last digit of the TOB means that value can vary from 0-9.

20 - Home Health Prospective Payment System (HH PPS) Consolidated Billing

(Rev. 10758; Issued: 05-11-21; Effective: 01-01-22; Implementation: 08-11-21)

Section 1842 (b)(6)(F) of the Social Security Act requires consolidated billing of all home health services while a beneficiary is under a home health plan of care authorized by a physician. Consequently, Medicare makes payment for all such items and services to a single HHA overseeing that plan. This HHA is known as the primary HHA for HH PPS billing purposes.

The law states payment will be made to the primary HHA without regard as to whether or not the item or service was furnished by the agency, by others under arrangement to the primary agency, or when any other contracting or consulting arrangements exist with the primary agency, or “otherwise.” Payment for all items is included in the HH PPS payment the primary HHA receives.

Types of services that are subject to the home health consolidated billing provision:

- Skilled nursing care;
- Home health aide services;
- Physical therapy;
- Speech-language pathology;
- Occupational therapy;
- Medical social services;
- Routine and nonroutine medical supplies;
- Medical services provided by an intern or resident-in-training of a hospital, under an approved teaching program of the hospital, in the case of an HHA that is affiliated or under common control with that hospital; and

- Care for homebound patients involving equipment too cumbersome to take to the home.

Exception: Therapy services are not subject to the home health consolidated billing methodology when performed by a physician.

Medicare periodically publishes Recurring Update Notifications that contain updated lists of nonroutine supply codes and therapy codes that must be included in home health consolidated billing. Medicare updates the lists annually, effective January 1, as a result of annual changes in HCPCS codes, unless the HCPCS changes do not affect home health services. The lists may also be updated as frequently as quarterly if this is required by the creation of new HCPCS codes mid-year.

The HHA that submits an NOA successfully processed by Medicare claims processing systems will be recorded as the primary HHA for a given period in the CWF. If a beneficiary transfers during a 30-day period of care, then the transfer HHA that establishes the new plan of care assumes responsibility for consolidating billing for the beneficiary. A/B MACs (HHH) will reject any claims from providers or suppliers other than the primary HHA that contain billing for the services and items subject to consolidated billing when billed for dates of service within a period of care (see §20.2 for details).

A/B MACs (HHH) will also reject claims subject to consolidated billing when submitted by the primary HHA as services not under an HH plan of care (using TOB 034x) when the primary HHA has already billed other services under an HH plan of care (TOB 032x) for the beneficiary. Institutional providers may access information on existing periods of care through the home health CWF inquiry process. See §30.1.

Durable medical equipment is exempt from home health consolidated billing by law. Therefore, DME may be billed by a supplier or an HHA (including HHAs other than the primary HHA). Medicare claims processing systems will allow either party to submit DME claims, but will ensure that the same DME items are not submitted by multiple providers for the same dates of service for the same beneficiary. In the event of duplicate billing, the first claim received will be processed and paid. Subsequent duplicate claims will be denied. Medicare claims processing systems will also prevent payment for the purchase and the rental of the same item for the same dates of service. In this event, the first claim received, regardless of whether for purchase or rental, will be processed and paid.

The exception to the above, however, is competitive bidding for certain DME. HHAs that furnish DME and are located in an area where DME items are subject to a competitive bidding program, must either be awarded a contract to furnish the items in this area or use a contract supplier in the community to furnish these items. The competitive bidding items are identified by HCPCS codes and the competitive bidding areas are identified based on ZIP Codes where beneficiaries receiving these items maintain their permanent residence. Home health agency claims submitted for HCPCS

codes subject to a competitive bidding program will be returned to the provider to remove the affected DME line items and the providers will be advised to submit those charges to the DME MACs, who will have jurisdiction over all claims for competitively bid items.

Osteoporosis drugs are subject to home health consolidated billing, even though these drugs continue to be paid on a cost basis in addition to the HH unit of payment. For more detailed information, refer to §20.2.3 and §90.1.

20.1 - Beneficiary Notification and Payment Liability Under Home Health Consolidated Billing

(Rev. 635, Issued: 08-05-05; Effective: 10-01-00; Implementation: 11-03-05)

20.1.1 - Responsibilities of Home Health Agencies

(Rev. 10758; Issued: 05-11-21; Effective: 01-01-22; Implementation: 08-11-21)

Medicare payment for services subject to home health consolidated billing is made to the primary HHA, so separate Medicare payment for these services will never be made. The primary HHA is responsible for providing these services, either directly or under arrangement. This responsibility applies to all services that the physician has ordered on the beneficiary's home health plan of care.

However, providing services either directly or under arrangement requires knowledge of the services provided during the period of care. An HHA would not be responsible for payment to another provider in the situation in which they have no prior knowledge (e.g., they are unaware of physicians orders) of the services provided by that provider to a patient who is under their home health plan of care.

In certain circumstances where the primary HHA is unaware of services provided during the period of care and the beneficiary is properly notified, the beneficiary may be liable for payment for these services. In order to protect the beneficiary from unexpected liability in these cases, and in order to comply with Medicare Conditions of Participation, it is important that all providers and suppliers serving a home health patient notify the beneficiary of the possibility that they will be responsible for payment.

Notification about home health consolidated billing must begin with the beneficiary's admission to home health care. Under the Medicare Home Health Services Conditions of Participation: Patient rights, (42 CFR, §484.10 (c) (i)), the HHA must advise the patient, in advance, of the disciplines (e.g., skilled nursing, physical therapy, home health aide, etc.) that will furnish care, and the frequency of visits proposed to be furnished. It is, therefore, the responsibility of the HHA to fully inform beneficiaries that all home health services, including therapies and supplies, will be provided by his/her primary HHA.

In addition, under the Conditions of Participation: Patient liability for payment, (42 CFR, §484.10(e)), HHAs are responsible for advising the patient, in advance, about the extent to which payment is expected from Medicare or other sources, including the patient. Information regarding patient liability for payment must be provided by the HHA both

orally and in writing. This should assist in alerting the beneficiary to the possibility of payment liability if he/she were to obtain services from anyone other than their primary HHA.

HHAs are also responsible for the timely submission of a Notice of Admission (NOA). This ensures information about their primary HHA status is available to other providers.

20.1.2 - Responsibilities of Providers/Suppliers of Services Subject to Consolidated Billing

(Rev. 10758; Issued: 05-11-21; Effective: 01-01-22; Implementation: 08-11-21)

Since Medicare payment for services subject to home health consolidated billing is made to the primary HHA, providers or suppliers of these services must be aware that separate Medicare payment will not be made to them. Therefore, before they provide services to a Medicare beneficiary, these providers or suppliers need to determine whether or not a home health period of care exists for that beneficiary. This information may be available to providers or suppliers from a number of sources.

The first avenue a therapy provider or a supplier may pursue is to ask the beneficiary (or his/her authorized representative) if he/she is presently receiving home health services under a home health plan of care. Beneficiaries and their representatives should have the most complete information as to whether or not they are receiving home health care. Therapy providers or suppliers may, but are not required to, document information from the beneficiary that states the beneficiary is not receiving home health care, but such documentation in itself does not shift liability to either the beneficiary or Medicare.

Additionally, information about current home health periods of care may be available from MACs. Institutional providers may access this information electronically through the home health CWF inquiry process (See §30.1). Independent therapists or suppliers who bill using the professional claim format also have access to a similar electronic inquiry via the HIPAA Eligibility Transaction System (HETS). They may also, as a last resort, call their A/B MAC (B)'s provider toll free line to request home health eligibility information available on the Common Working File. The A/B MAC (B)'s information is based only on claims Medicare has received from home health agencies at the day of the contact.

Medicare systems maintain a data file that captures and displays the dates when Medicare paid physicians for the certification or recertification of the beneficiary's HH plan of care. Physicians submit claims for these services to A/B MACs (B) on the professional claim format separate from the HHA's billing their claim on the institutional claim format for the HH services themselves.

There may be instances in which the physician claim for the certification service is received before any HHA billing and this claim is the earliest indication Medicare systems have that HH services will be provided. As an aid to suppliers and providers subject to HH consolidated billing, Medicare systems display, for each Medicare beneficiary, the code for certification (G0180) or recertification (G0179) and the date of service for either of the two codes.

Suppliers and providers should note that this information is supplementary to the previously existing sources of information about HH periods of care. Like HH period of care information maintained on CWF, certification information is only as complete and timely as billing by providers allows. For many periods of care, a physician certification claim may never be billed. As a result, the beneficiary and their caregivers remain the first and best source of information about the beneficiary's home health status.

If a therapy provider or a supplier learns of a home health period of care from any of these sources, or if they believe they don't have reliable information, they should advise the beneficiary that if the beneficiary decides not to have the services provided by the primary HHA and the beneficiary is in an HH period, the beneficiary will be liable for payment for the services. Beneficiaries should be notified of their potential liability before the services are provided.

If a therapy provider or a supplier learns of a home health period of care and has sufficient information to contact the primary HHA, they may inquire about the possibility of making a payment arrangement for the service with the primary HHA. Such contacts may foster relationships between therapy providers, suppliers and HHAs that are beneficial both to providers involved and to Medicare beneficiaries.

20.1.3 - Responsibilities of Hospitals Discharging Medicare Beneficiaries to Home Health Care

(Rev. 635, Issued: 08-05-05; Effective: 10-01-00; Implementation: 11-03-05)

A hospital discharging a Medicare beneficiary to home health care can also play an important role in alerting the beneficiary to their potential liability under home health consolidated billing. Under the Medicare Conditions of Participation (COP) for Hospitals: Discharge planning, (42 CFR, §482.43 (b) (3) and (6)), hospitals must have in effect a discharge planning process that applies to all patients, and the discharge planning evaluation must include an evaluation of the likelihood of a patient needing post-hospital services and of the availability of the services. The hospital must include the discharge planning evaluation in the patient's medical record for use in establishing an appropriate discharge plan and the hospital must discuss the results of the evaluation with the patient or individual acting on his or her behalf. In addition, under 42 CFR, §482.43 (c) (5), the patient and family members must be counseled to prepare them for post-hospital care and under 42 CFR, §482.43 (d) Transfer or referral, the hospital must transfer or refer

patients, along with necessary medical information, to appropriate facilities, agencies, or outpatient services, as needed, for followup or ancillary care.

Hospitals, therefore, should counsel beneficiaries being discharged to receive home health services, that his/her "primary" home health agency; i.e., the agency establishing his/her plan of care, will provide all home health services. Hospitals should provide a list of home health agencies for beneficiaries to choose from; in addition, when referring the beneficiary to his/her chosen home health agency, the hospital should notify the agency and include any counseling notes, which should serve as a reminder to the home health agency to also notify the beneficiary that all home health services will be provided by them as the "primary" home health agency. Hospitals play a key role in making beneficiaries, and/or their caregivers, aware of Medicare home health coverage policies to help ensure that those services are provided appropriately.

20.2 - Home health Consolidated Billing Edits in Medicare Systems

(Rev. 10758; Issued: 05-11-21; Effective: 01-01-22; Implementation: 08-11-21)

In short, consolidated billing requires that only the primary HHA bill services under the home health benefit, with the exception of DME and therapy services provided by physicians, for the period of that period of care. The types of service most affected are nonroutine supplies and outpatient therapies, since these services are routinely billed by providers other than HHAs, or are delivered by HHAs outside of plans of care.

Home health consolidated billing edits are applied when the period of care claim has been received and processed in CWF. Edits are applied differently depending on whether the HH patient was discharged/transferred at the end of the HH period or not.

If the patient was discharged or transferred, the edits apply to dates of service between the period start date and the last billable service date for the period. The start date and last service date are excluded.

If the patient is not discharged or transferred (patient status 30, "Still Patient"), the edits apply to dates of service between the period start date and the period end date. The start date is excluded but the end date is included.

If any line item services subject to consolidated billing are identified within these dates, CWF sends information to the contractors that enables them to reject or deny those line items.

Claims subject to consolidated billing may be identified in one of two ways. Claims may be edited when the HH PPS claim had been received before the claim for services subject to consolidated billing. In these cases, the line items subject to consolidated billing are rejected or denied prior to payment. Claims may also be identified when the HH PPS claim is received after the other claims subject to consolidated billing. In these cases, the claim for services subject to consolidated billing has already been paid. CWF then notifies the contractor to make a post-payment rejection or denial.

For post-payment rejections of claims billed on institutional claims, recoveries will be made automatically in the claims process. For post-payment rejections of claims billed on professional claims, those contractors will follow their routine overpayment identification and recovery procedures. In the event a denial is reversed upon appeal, an override procedure exists to permit payment to be made.

The contractor shall use the following remittance advice messages and associated codes when not paying outlier amounts under this policy. This CARC/RARC combination is compliant with CAQH CORE Business Scenario Four.

Group Code: CO
CARC: 97
RARC: N390
MSN: N/A

Since home health consolidated billing is not an ABN situation, coding on incoming claims cannot allow Medicare systems to fully identify the payment liability for any denial. As described in §20.1, whether the denial is the liability of the primary HHA or the beneficiary is determined by whether the services are provided under arrangement and whether the beneficiary received notice of their potential liability. These denials are shown as provider liability on remittance advices (group code CO) to ensure therapy providers or suppliers explore whether a payment arrangement exists or can be made for the services. Despite this coding limitation, Medicare recognizes that ultimately beneficiaries may be liable for these services.

20.2.1 - Nonroutine Supply Editing

(Rev. 2977, Issued; 06-20-14, Effective: 09-23-14; ICD-10: Upon Implementation of ICD-10, Implementation: 09-23-14; ICD-10: Upon Implementation of ICD-10)

For home health consolidated billing, nonroutine medical supplies are identified as a list of discrete items by HCPCS code. Supplies are billed to DME MACs using the professional claim format, in which line items have both a 'from' and 'to' date. The line item 'from' date is used to enforce consolidated billing of nonroutine medical supplies.

Claims submitted by providers using the institutional claim format may include a nonroutine supply HCPCS code in addition to the other services provided. These supplies are either bundled into the rate paid for the primary service or are otherwise incident to the primary service(s) being rendered, therefore these supplies do not fall within the bundling provisions of HH PPS. As a result, supplies reported on institutional claims are not subject to consolidated billing edits by CWF.

20.2.2 - Therapy Editing

(Rev. 10758; Issued: 05-11-21; Effective: 01-01-22; Implementation: 08-11-21)

On claims submitted by providers using the institutional claim format, CWF enforces consolidated billing for outpatient therapies by recognizing as therapies all services billed under revenue codes 042x, 043x, 044x. These revenue codes are subject to consolidated billing when submitted on types of bill 013x, 023x, 034x, 074x, 075x or 085x. Consolidated billing edits do not apply on TOB 034x when the HHA is billing for disposable negative pressure wound therapy services during an HH period of care.

On claims submitted by practitioners using the professional claim format, CWF enforces consolidated billing for outpatient therapies using a list of HCPCS codes which represent therapy services.

Therapy services on professional claims are not subject to the home health consolidated billing methodology when performed by a physician. Therefore, CWF bypasses the therapy edit if the HCPCS code is a therapy code subject to home health consolidated billing but the specialty code on the claim indicates a physician.

The following specialty codes indicate a physician for purposes of this edit:

Code	Physician Specialty
01	General Practice
02	General Surgery
03	Allergy/Immunology
04	Otolaryngology
05	Anesthesiology
06	Cardiology
07	Dermatology
08	Family Practice
09	Interventional Pain Management
10	Gastroenterology
11	Internal Medicine
12	Osteopathic Manipulative Therapy
13	Neurology
14	Neurosurgery
16	Obstetrics/Gynecology
18	Ophthalmology

Code	Physician Specialty
19	Oral Surgery (dentists only)
20	Orthopedic Surgery
22	Pathology
24	Plastic and Reconstructive Surgery
25	Physical Medicine and Rehabilitation
26	Psychiatry
28	Colorectal Surgery (formerly proctology)
29	Pulmonary Disease
30	Diagnostic Radiology
33	Thoracic Surgery
34	Urology
35	Chiropractic
36	Nuclear Medicine
37	Pediatric Medicine
38	Geriatric Medicine
39	Nephrology
40	Hand Surgery
41	Optometry
44	Infectious Disease
46	Endocrinology
48	Podiatry
66	Rheumatology
70	Single or Multispecialty Clinic or Group Practice
72	Pain Management
76	Peripheral Vascular Disease
77	Vascular Surgery
78	Cardiac Surgery
79	Addiction Medicine
81	Critical Care (Intensivists)
82	Hematology
83	Hematology/Oncology

Code	Physician Specialty
84	Preventive Medicine
85	Maxillofacial Surgery
86	Neuropsychiatry
90	Medical Oncology
91	Surgical Oncology
92	Radiation Oncology
93	Emergency Medicine
94	Interventional Radiology
98	Gynecological/Oncology
99	Unknown Physician Specialty

20.2.3 - Other Editing Related to Home Health Consolidated Billing

(Rev. 10758; Issued: 05-11-21; Effective: 01-01-22; Implementation: 08-11-21)

CWF edits to prevent duplicate billing across two providers. Consequently, CWF must edit to ensure that all DME items billed by HHAs have a line-item date of service and HCPCS code, even though HH consolidated billing does not apply to DME by law.

If revenue code 0636 and the HCPCS code for an osteoporosis drug is billed on a TOB 034x claim during an open HH period of care, CWF ensures that the provider of the 034x claim is the same as the primary provider of the open period of care, since by law consolidated billing must also be applied to the osteoporosis drug even though this item is paid outside of the unit of payment. HH consolidated billing will not affect billing of DME or services outside the home health benefit, even when these services are billed by HHAs.

20.2.4 - Only Notice of Admission (NOA) Received and Services Fall Within Admission Period

(Rev. 10758; Issued: 05-11-21; Effective: 01-01-22; Implementation: 08-11-21)

If only an NOA has been received and the incoming claim with services subject to consolidated billing contains dates of service within the HH admission period, CWF returns an alert to the Medicare contractor to notify them that the claim may be subject to consolidated billing. The Medicare contractor processes the claim to payment, but passes on the alert to the provider on the remittance advice at the line level.

The contractor shall use the following remittance advice messages and associated codes when making payment under this policy. The CARC below is not included in the CAQH CORE Business Scenarios.

Group Code: CO
CARC: N/A
RARC: N88
MSN: N/A

This indicates to providers that the services may be denied and claim payment may be recouped if later editing or another post-payment recovery process identifies the claim as subject to consolidated billing.

20.2.5 - No NOA Received and Therapy Services Rendered in the Home

(Rev. 10758; Issued: 05-11-21; Effective: 01-01-22; Implementation: 08-11-21)

There may be situations in which a beneficiary is under a home health plan of care, but CWF does not yet have a record of either an NOA or a home health claim for the period of care. To help inform independent therapy providers billing professional claims to Medicare contractors that the services they rendered in the home setting may be subject to consolidated billing, providers will receive notification on the remittance advice when Medicare pays them for the service.

Medicare systems processing professional claims will provide this notification when the place of service on the claim is "12 home," the HCPCS code is a therapy code subject to home health consolidated billing and CWF has not returned a message indicating the presence of an NOA.

30 - Common Working File (CWF) Requirements for the Home Health Prospective Payment System (HH PPS)

(Rev. 1, 10-01-03)
HH-468, A3-3640

30.1 - Eligibility Query to Determine Status

(Rev. 10758; Issued: 05-11-21; Effective: 01-01-22; Implementation: 08-11-21)

Under the HH PPS and home health consolidated billing one HHA is considered the "primary" home health agency in billing situations. This primary agency is the only agency that may bill Medicare for home care for a given homebound beneficiary at a specific time. When a homebound beneficiary seeks care from an HHA or from an institutional therapy provider subject to home health consolidated billing, the provider needs to determine if the beneficiary is already being served by an HHA - an agency that then would be considered primary.

Providers may send an inquiry to determine the beneficiary's entitlement and eligibility status into the Common Working File or CWF, through their A/B MAC (A) or (HHH). They must send the ASC X12 270 Health Care Eligibility Inquiry transaction set and will receive the ASC X12 271 Health Care Eligibility Response transaction set in response, in order to comply with the requirements of the Health Insurance Portability and Accountability Act.

A/B MACs (A) or (HHH) processing institutional claims will create an ELGH record from the 270 to request this data from CWF and will receive the ELGA record from CWF in response. The A/B MAC (A) or (HHH) will create the 271 response or DDE screen from the ELGA transaction record.

The response shows whether or not the beneficiary is currently in a home health admission period. If the beneficiary is not already under care at another HHA, he/she can be admitted to the inquiring HHA, and that agency will become primary. The beneficiary can also be admitted even if an admission period is already open at another HHA if the beneficiary has chosen to transfer.

See chapter 31 for a description of the data elements and related requirements.

30.2 - CWF Response to Inquiry

(Rev. 10758; Issued: 05-11-21; Effective: 01-01-22; Implementation: 08-11-21)

CWF will return information on the two periods of care in the CWF episode file closest to the date the HHA or other provider entered in the "applicable date" field. If a date is not specified, information on the two most recent periods of care will be returned. See Chapter 31 for complete data sets returned to specific provider types.

30.3 - Timeliness and Limitations of CWF Responses

(Rev. 10758; Issued: 05-11-21; Effective: 01-01-22; Implementation: 08-11-21)

Inquirers receive a response within a very short time frame. However, these responses are not truly "real time." The CWF auxiliary file that retains admission period and period of care information is updated by, and is only as current as, each NOA or claim batch run in CWF. All processed NOAs and claims will update the file, even if claims are ultimately denied. The CWF removes periods from the file only when:

- HHAs cancel their own NOA for a period of care that includes no subsequent claims;
- HHAs cancel their own claims for periods that were not initially created by an NOA; or

- When a A/B MAC (HHH) processing HH claims cancels an NOA or a claim for specific reasons (i.e., fraud).

In general, responses will be as current as the previous day. Therefore, even when a response indicates a beneficiary is not currently in an admission period, the possibility exists that an NOA or claim could be in process, and the inquiring agency would still not be the primary HHA for a beneficiary for whom a "clear" inquiry was received. In such cases, the inquiring agency will not learn that it is not the primary HHA immediately.

Also possible but even more rare, NOAs or claims from two different HHAs for the same beneficiary for the same date may be in the same batch sent to CWF. In such cases, the claim process will result in one of the two transactions being processed first and thereby deciding which of the two agencies will be primary.

30.4 - Provider/Supplier Inquiries to MACs Based on Eligibility Responses

(Rev. 1348, Issued: 10-05-07, Effective: 01-01-08, Implementation: 11-05-07)

Institutional providers and/or suppliers may want to follow-up on information they receive, usually to contact the primary agency on file to bill under arrangement. The provider or supplier may determine the HHA's A/B MAC (HHH) from the CMS Web site which has a list of A/B MACs (HHH) that process HH claims by State. The provider or supplier also may ask its own MAC through existing provider inquiry channels. That MAC will instruct the provider regarding which A/B MAC (HHH) that processes HH claims to contact to learn which HHA is involved.

A/B MACs (HHH) that process HH claims may provide information on either the provider or A/B MAC (HHH) that these providers may request. Information released will be determined by each MAC, such as HHA name and address, but must be enough for the inquiring provider/supplier to contact either the primary HHA, if under that A/B MAC (HHH)'s jurisdiction, or another A/B MAC (HHH), if the provider number is attached to another A/B MAC (HHH). If an instance ever exists where a provider is an individual, such as a provider doing business using a Social Security Number as a tax identification number, information cannot be released, since it would violate the individual's right to privacy.

30.5 - National Home Health Prospective Payment Episode History File

(Rev. 10758; Issued: 05-11-21; Effective: 01-01-22; Implementation: 08-11-21)

CWF maintains a national history file for each beneficiary in order to enforce consolidated billing and perform HH PPS processing. Even though under the PDGM, the HH unit of payment is a 30-day period of care, this file continues to be named 'the episode file' in CWF. Only MACs, not providers, may view this file.

The episode file, populated as soon as an admission period is opened for a beneficiary with an NOA, contains:

- The beneficiary identifier;
- Period Start and End Dates - the start date is received on an NOA or claim, and the end date is initially calculated to be the 30th day after the start date, changed as necessary when the claim for the period is finalized;
- The pertinent A/B MAC (HHH), CMS Certification Number and National Provider Identifier;
- The HRG Code - the HIPPS code used to determine payment for the period of care;
- Date of Earliest Billing Activity (DOEBA) and Date of Latest Billing Activity (DOLBA) –line item dates of service of the first and last HH visits reported on the claim for the period of care;
- Patient Status Indicator - the patient discharge status code on an HH PPS claim, indicating the status of the HH patient at the end of the period of care.
- Cancellation Indicator – Indicates if the claim has been denied as fully non-covered by medical review. In these cases, the indicator is a value of "2." In all other cases, the value is "0."
- NOA Indicator – Indicates the period was initially created by an NOA, not a claim. If the NOA is submitted as a transfer, with condition code 47, this indicator is set to '2.' For any other NOAs, this indicator is set to '1.' If a period is created by a continuing claim, this indicator is blank.

The episode file contains the 36 most recent periods of care for any beneficiary. Periods that precede the most recent 36 will be dropped off the file and will not be retrievable online.

30.6 - Opening and Length of HH PPS Episodes/Periods of Care

(Rev. 10758; Issued: 05-11-21; Effective: 01-01-22; Implementation: 08-11-21)

Within CWF, the episode history auxiliary file is separate from the home health benefit period auxiliary file (labeled HHEH), which existed prior to HH PPS and is used to administer payment of HH services from the correct Medicare Trust Fund. All HH PPS claims update both these files. NOAs only update the episode history file.

The initial 30-day period of care is created on this file based on the NOA. The start date of this period of care is also used to indicate the start date of an HH admission period. The HH admission period is a claims processing concept used to correctly enforce primary HHA assignment and HH consolidated billing.

Medicare systems determine a claim to fall within an HH admission period if it is within an admission period start and end date OR if it is on or after the start date of a period that remains open. Medicare systems determine the span of an admission period from HHEH period information as follows:

Admission Period Start Date: The HHEH Period Start Date when the NOA indicator is 1 or 2.

Admission Period End Date:

- The HHEH Period End Date when the patient status on latest HHEH period in a series of contiguous periods indicates a discharge (the code is other than 30), or
- The HHEH Start Date of a subsequent HHEH period when the NOA indicator on the subsequent period is 1 or 2.

If an NOA with a different provider number falls within an admission period and does not report a transfer using condition code 47, the NOA will be returned to the provider because the HHA is not the primary HHA for that beneficiary. If a claim subject to HH consolidated billing falls within an admission period, but does not fall within dates that reflect an HH claim has been paid, the claim will receive an alert as described in section 20.2.5.

The initial 30-day period of care created by the NOA is updated by the claim for that period. All subsequent periods of care in the admission will be created by the subsequent claims.

Multiple periods can be open for the same beneficiary at the same time. The same HHA may require multiple periods be opened for the same beneficiary because of an unexpected readmission after discharge. Multiple periods may also occur between different providers if a transfer situation exists. CWF will post NOAs received with appropriate transfer and readmit indicators to facilitate the creation of multiple periods.

Same day transfers are permitted, such that a period of care for one agency can end on the same date as a period of care was opened by another agency for the same beneficiary. Both HHA's services for this date will be approved for payment, without regard for whether the same HH disciplines (e.g. skilled nursing, physical therapy, etc.) from both HHAs provided services.

When periods of care are created from NOAs, CWF calculates a period end date that does not exceed the start date plus 29 days. CWF will assure no period exceeds the maximum length under any circumstance, and will auto-adjust the period end date to shorten the period if needed based on subsequent NOA or claim submissions (i.e., shortened by transfer).

30.7 - RESERVED

(Rev. 10758; Issued: 05-11-21; Effective: 01-01-22; Implementation: 08-11-21)

30.8 - RESERVED

(Rev. 10758; Issued: 05-11-21; Effective: 01-01-22; Implementation: 08-11-21)

30.9 - Coordination of HH PPS Claims Episodes With Inpatient Claim Types

(Rev. 4312, Issued: 05-23-19, Effective: 01-01-20, Implementation: 08-16-19)

Beneficiaries cannot be institutionalized and receive home health care simultaneously. Therefore claims for institutional inpatient services (inpatient hospital, skilled nursing facility (SNF) and swing bed claims), have priority in Medicare claims editing over claims for home health services.

If an HH PPS claim is received, and CWF finds dates of service on the HH claim that falls within the dates of an inpatient, SNF or swing bed claim (not including the dates of admission and discharge and the dates of any leave of absence), Medicare systems will reject the HH claim. The HHA may submit a new claim removing any dates of service within the inpatient stay that were billed in error.

If the HH PPS claim is received first and the inpatient hospital, SNF or swing bed claim comes in later, but contains dates of service duplicating dates of service on the HH PPS claim, Medicare systems will adjust the previously paid HH PPS claim to non-cover the duplicated dates of service.

30.10 – RESERVED

(Rev. 4312, Issued: 05-23-19, Effective: 01-01-20, Implementation: 08-16-19)

30.11 - Exhibit: Chart Summarizing the Effects of NOA/Claim Actions on the HH PPS Episode File

(Rev. 10758; Issued: 05-11-21; Effective: 01-01-22; Implementation: 08-11-21)

The following chart summarizes basic effects of HH PPS claims processing on the episode record. Even though under the PDGM, the HH unit of payment is a 30-day period of care, this file continues to be named 'the episode file' in CWF and references to 'episode record' below refer to periods of care.

Transaction	How CWF Is Impacted	How Other Providers Are Impacted
NOA	• Opens an episode record using NOA "From" date to set Period Start Date • CWF uses Start Date to calculate admission period • Period End Date is automatically calculated to extend through 30th day • DOEBA and DOLBA are left blank • NOA indicator is set to 1	• Other NOAs submitted during this open admission period will be rejected unless an indicator of a transfer or discharge/readmission is present
NOA with condition code 47	• Opens an episode record using NOA's "From" date to set Period Start Date • Period End Date is automatically calculated to extend through 30th day • DOEBA and DOLBA are left blank • The Period End Date (if later than the NOA "From" date) is automatically changed to reflect the NOA's "from" date. • NOA indicator is set to 2 • CWF uses the new Start Date as the end date of the previous admission period.	• The Period End Date created by the NOA or claim of the HHA the beneficiary is transferring from is automatically changed to reflect the "from" date on the NOA submitted by the HHA the beneficiary is transferring to. The HHA the beneficiary is transferring from cannot bill for services past the date of transfer. • Another HHA cannot bill during this episode unless another transfer NOA is submitted.

Transaction	How CWF Is Impacted	How Other Providers Are Impacted
NOA Cancellation by Provider (TOB 032D)	• The episode record is deleted from CWF	• No episode record is present to prevent NOA submission by another provider, making that provider the primary HHA for the dates of the episode
Claim (full 30-day period, patient status 30)	• 30-day record is completed • Period End Date remains at the 30th day • DOEBA is updated to reflect first visit date in period • DOLBA is updated to reflect last visit date in episode • CWF considers the admission period still open.	• Other NOAs submitted during this open period will be rejected unless an indicator of a transfer or discharge/readmission is present
Claim (discharge with goals met prior to Day 30)	• 30-day record is completed • Period End Date remains at the 30th day; • DOEBA is updated to reflect first visit date in episode • DOLBA is updated to reflect last visit date in episode • CWF uses the Period End Date as the end date of the admission period also.	• Other NOAs submitted with "From" dates before the end date of this period will be rejected unless an indicator of a transfer or discharge/readmission is present

Transaction	How CWF Is Impacted	How Other Providers Are Impacted
Claim (transfer)	• Episode record completed • Period End Date reflects claim "Through" date; • DOEBA is updated to reflect first visit date in episode • DOLBA is updated to reflect last visit date in episode • CWF uses the Period End Date as the end date of the admission period also.	• An NOA will be accepted if the "From" date is on or after period "Through" date
Claim Adjustment	• No impact unless adjustment changes patient status to transfer or service lines are added or removed to change the DOEBA or DOLBA date.	• No impact
Claim Cancellation	• The period is deleted from CWF unless an NOA indicator of 1 or 2 is present. • If an NOA indicator is present, the HIPPS code and DOEBA/DOLBA dates are removed but the period remains in the file.	• No impact

40 - Completion of Form CMS-1450 for Home Health Agency Billing

(Rev. 3021, Issued: 08-08-14, Effective: 01-01-12, Implementation: 09-08-14)

The Social Security Act at §1862 (a)(22) requires that all claims for Medicare payment must be submitted in an electronic form specified by the Secretary of Health and Human Services, unless an exception described at §1862 (h) applies. The electronic form required for billing home health services is the ASC X12 837 institutional claim transaction. Since the data structure of the 837 transaction is difficult to express in narrative form and to provide assistance to small providers excepted from the electronic claim requirement, the instructions below are given relative to the data element names on the Form CMS-1450 hardcopy form. Each data element name is shown in bold type. Information regarding the form locator numbers that correspond to these data element names is found in chapter 25.

Because claim formats serve the needs of many payers, some data elements may not be needed by a particular payer. This section provides detailed information only for items required for Medicare home health claims. Items not listed need not be completed although home health agencies may complete them when billing multiple payers. In all cases, the provider is responsible for filing a timely claim for payment. (See chapter 1.)

40.1 - Notice of Admission (NOA)

(Rev. 12106; Issued: 06-29-23, Effective: 01- 01-24; Implementation:01-02-24)

HHAs must send the NOA to the A/B MAC (HHH) by mail, electronic data interchange (EDI), or direct data entry (DDE). EDI submissions require additional data not required by the NOA itself, to satisfy transaction standards. This data is described in a companion guide available on the CMS website. HHAs may voluntarily agree to adopt the companion guide and use it to submit EDI NOAs at any time.

The following data elements are required to submit an NOA under HH PPS.

Provider Name, Address, and Telephone Number

Required - The minimum entry is the agency's name, city, State, and ZIP Code. The post office box number or street name and number may be included. The State may be abbreviated using standard post office abbreviations. Five or nine-digit ZIP Codes are acceptable. This information is used in connection with the CMS Certification Number to verify provider identity.

Type of Bill

Required -

032x - Home Health Services under a Plan of Treatment

4th Digit	Definition
A	Admission/Election Notice
D	Cancellation of Admission/Election Notice

Statement Covers Period (From-Through)

Required – The HHA reports the date of the first visit provided in the admission as the From date. The Through date on the NOA must always match the From date.

Patient Name/Identifier

Required - Patient's last name, first name, and middle initial.

Patient Address

Required - Patient's full mailing address, including street number and name, post office box number or RFD, City, State, and ZIP Code.

Patient Birth Date

Required - Month, day, and year of birth of patient.

Left blank if the full correct date is not known.

Patient Sex

Required - "M" for male or "F" for female must be present. This item is used in conjunction with diagnoses and surgical procedures to identify inconsistencies.

Admission/Start of Care Date

Required - The Admission date on the NOA must always match the From date.

Condition Codes

Conditional. - If the NOA is for a patient transferred from another HHA, the HHA enters condition code 47.

Note: No line item service information is required by the Medicare program to complete a Notice of Admission via DDE. However, certain line information is required to meet the requirements of the 837I claim format. See the NOA Companion Guide for details on meeting these requirements.

Release of Information Certification Indicator

Required - A "Y" code indicates the provider has on file a signed statement permitting the provider to release data to other organizations in order to adjudicate the claim. An "R" code indicates the release is limited or restricted. An "N" code indicates no release on file.

National Provider Identifier – Billing Provider

Required - The HHA enters their provider identifier.

Insured's Name

Required - On the same lettered line (A, B, or C) that corresponds to the line on which Medicare payer information is shown, record the patient's name as shown on the patient's HI card or other Medicare notice.

Insured's Unique Identifier

Required – *The HHA enters the beneficiary's Medicare Beneficiary Identifier (MBI). Confirm the MBI is active via an eligibility inquiry to avoid delays in the timely receipt or processing of the NOA.*

Principal Diagnosis Code

Required to meet the requirements of the 837I claim format. See the NOA Companion Guide

Attending Provider Name and Identifiers

Required - The HHA enters the name and provider identifier of the attending physician that has established the plan of care with verbal orders.

40.2 - HH PPS Claims

(Rev. 12382; Issued: 11-28-23; Effective: 01-01-24; Implementation:01-02-24)

The following data elements are required to submit a claim under home health PPS. For billing of home health claims not under an HH plan of care (not under HH PPS), see §90. Home health services under a plan of care are paid based on a 30-day period of care. HHAs submit an NOA at the beginning of an admission and then submit one claim for each 30-day period of care. Claims submitted before an NOA has been received for the beneficiary will be returned to the provider.

Billing Provider Name, Address, and Telephone Number

Required – The HHA's minimum entry is the agency's name, city, state, and ZIP Code. The post office box number or street name and number may be included. The state may be abbreviated using standard post office abbreviations. Five or nine-digit ZIP Codes are acceptable. A/B MACs (HHH) use this information in connection with the provider identifier to verify provider identity.

Patient Control Number and Medical/Health Record Number

Required - The patient's control number may be shown if the patient is assigned one and the number is needed for association and reference purposes.

The HHA may enter the number assigned to the patient's medical/health record. If this number is entered, the A/B MAC (HHH) must carry it through their system and return it on the remittance record.

Type of Bill

Required - This 4-digit alphanumeric code gives two pieces of information. The first three digits indicate the base type of bill. The fourth digit indicates the sequence of this bill in this particular period of care. The types of bill accepted for HH PPS claims are:

032x - Home Health Services under a Plan of Treatment

4th Digit - Definition

> 7 - Replacement of Prior Claim - HHAs use to correct a previously submitted bill. Apply this code for the corrected or "new" bill. These adjustment claims must be accepted at any point within the timely filing period after the payment of the original claim.
>
> 8 - Void/Cancel of a Prior Claim - HHAs use this code to indicate this bill is an exact duplicate of an incorrect bill previously submitted. A replacement claim must be submitted for the period of care to be paid.
>
> 9 - Final Claim for an HH PPS Period – This code indicates an HH original bill to be processed following the submission of an HH PPS Notice of Admission (TOB 032A)

HHAs must submit HH PPS claims with the 4th digit of "9." These claims may be adjusted with code "7" or cancelled with code "8." A/B MACs (HHH) do not accept late charge bills, submitted with code "5," on HH PPS claims. To add services within the period of a paid HH claim, the HHA must submit an adjustment.

Statement Covers Period

Required - The beginning and ending dates of the period covered by this claim. For continuous care periods, the "through" date must be 29 days after the "From" date for a 30-day period of care

In cases where the beneficiary has been discharged or transferred within the period, HHAs will report the date of discharge in accordance with internal discharge procedures as the "through" date. If the beneficiary has died, the HHA reports the date of death in the "through date."

The HHA may submit claims for payment immediately after the claim "through" date. It is not required to hold claims until the end of the period of care unless the beneficiary continues under care.

Patient Name/Identifier

Required - The HHA enters the patient's last name, first name, and middle initial.

Patient Address

Required - The HHA enters the patient's full mailing address, including street number and name, post office box number or RFD, City, State, and ZIP Code.

Patient Birth Date

Required - The HHA enters the month, day, and year of birth of patient. If the full correct date is not known, leave blank.

Patient Sex

Required - "M" for male or "F" for female must be present. This item is used in conjunction with diagnoses and surgical procedures to identify inconsistencies.

Admission/Start of Care Date

Required - The HHA enters a date of admission matching the From date on the first period of care in an admission. On subsequent periods of care, the HHA continues to submit the admission date reported on the first period of care.

Point of Origin for Admission or Visit

Required - The HHA enters the appropriate NUBC point of origin code.

Patient Discharge Status

Required - The HHA enters the code that most accurately describes the patient's status as of the "Through" date of the billing period. Any applicable NUBC approved code may be used.

Patient status code 06 should be reported in all cases where the HHA is aware that the period of care will be paid a partial period payment adjustment. These are cases in which the agency is aware that the beneficiary has transferred to another HHA within the 30-day period, or the agency is aware that the beneficiary was discharged with the goals of the original plan of care met and has been readmitted within the period. Situations may occur in which the HHA is unaware at the time of billing the discharge that these circumstances exist. In these situations, Medicare claims processing systems will adjust the discharge claim automatically to reflect the partial period payment adjustment, changing the patient status code on the paid claims record to 06.

In cases where the ownership of an HHA is changing and the CMS certification number (CCN) also changes, the service dates on the claims must fall within the effective dates of the terminating CCN. To ensure this, all periods of care with "from" dates before the

termination date of the CCN that would extend beyond the termination date must be resolved by the provider submitting claims with "through" dates on or before the termination date. The provider must code the claim with patient status 06. Billing for the beneficiary is being "transferred" to the new agency ownership. In changes of ownership which do not affect the CCN, billing is unaffected.

In cases where an HHA is aware in advance that a beneficiary will become enrolled in a Medicare Advantage (MA) Organization as of a certain date, the provider should submit a claim for the shortened period prior to the MA Organization enrollment date. The provider must code the claim with patient status 06. Payment responsibility for the beneficiary is being "transferred" from Medicare fee-for-service to MA Organization, since HH PPS applies only to Medicare fee-for-service.

In cases where an HHA provides care in a 30-day period of care and then discharges the beneficiary in the next 30-day period of care, but does not provide any billable visits in the next 30-day period, special handling of the patient status code may be needed. Normally, the patient status code for 30-day period before the discharge would be 30, since the beneficiary has not yet been discharged. However, since there will not be a claim for the period in which the discharge occurred, this would result in the HH admission period remaining open in Medicare systems and prevent billing for any later HH services.

In order to close the HH admission period in these cases, the HHA should report patient status 01 on the claim for the last 30-day period in which visits occurred. This will trigger Medicare systems to close the HH admission period. If the claim has been submitted with patient status 30 before the discharge occurred, the HHA should adjust the claim to change the patient status to 01.

If the cause of the discharge in the next 30-day period is a transfer to another HHA before any visits were provided, the HHA should take care not to report patient status 06 on the claim. This would result in an incorrect partial period payment adjustment. If the cause of the discharge in the next 30-day period is the beneficiary's death, the HHA should take care not to report patient status 20 on the claim. This would result in an incorrect date of death being recorded in Medicare systems and potentially affect claims from other providers.

Condition Codes

Conditional – The HHA enters any NUBC approved code to describe conditions that apply to the claim.

If the claim is for a patient transferred from another HHA, the HHA enters condition code 47.

If the claim is for a period of care in which there are no skilled HH visits in the billing period, but a policy exception that allows billing for covered services is documented at the HHA, the HHA enters condition code 54.

As a result of disaster conditions (such as hurricane or wildfire) that render submission of OASIS assessments impossible, Medicare may issue a waiver indicating OASIS submission is waived. In this case, HHAs should report condition code DR on their claim to indicate billing under the waiver. Since the OASIS assessment cannot be submitted, the HHA cannot report occurrence code 50 to show the assessment completion date. Claims without occurrence code 50 will be accepted if condition code DR is present.

When a provider is unable to submit a start of care OASIS for an admission period of care, they should submit the HIPPS code weighted closest to 1. For a period of continuing care, when a provider is unable to submit a follow-up OASIS, they should carry forward the last HIPPS code generated from the previous OASIS.

If as a result of disaster conditions, OASIS submission timeframes are relaxed, HHAs should submit claims without condition code DR as soon as the OASIS was submitted. In this case, matching OASIS assessment information and the occurrence code 50 date are required to ensure Medicare pays the claim accurately.

HHAs that are adjusting previously paid claims enter one of the condition codes representing Claim Change Reasons (code values D0 through E0). If adjusting the claim to correct a HIPPS code, HHAs use condition code D2 and enter "Remarks" indicating the reason for the HIPPS code change. HHAs use D9 if multiple changes are necessary.

When submitting an HH PPS claim as a demand bill, HHAs use condition code 20. See §50 for more detailed instructions regarding demand billing.

When submitting an HH PPS claim for a denial notice, HHAs use condition code 21. See §60 for more detailed instructions regarding no-payment billing.

Required - If canceling the claim (TOB 0328), HHAs report the condition codes D5 or D6 and enter "Remarks" indicating the reason for cancellation of the claim.

Occurrence Codes and Dates

Required – The HHA enters occurrence code 50 and the date the OASIS assessment corresponding to the period of care was completed (OASIS item M0090). If occurrence code 50 is not reported on a claim or adjustment, the claim will be returned to the provider for correction, unless condition code DR is present to indicate a waiver of OASIS reporting is in effect.

On claims for initial periods of care (i.e. when the From and Admission dates match), the HHA reports an inpatient admission that ended within 14 days of the "From" date by using one of the following codes.

Code	Short Descriptor	Long Descriptor
61	Hospital Discharge Date	The Through date of a hospital stay that ended within 14 days prior to the From date this HHA claim.
62	Other Institutional Discharge Date	The Through date of skilled nursing facility (SNF), inpatient rehabilitation facility (IRF), long term care hospital (LTCH) or inpatient psychiatric facility (IPF) stay that ended within 14 days prior to this HHA admission.

On claims for continuing periods of care, the HHA reports an inpatient hospital admission that ended within 14 days of the "From" date by using occurrence code 61.

To determine the 14 day period, include the "From" date, then count back using the day before the "From" date as day 1. For example, if the "From" date is January 20th, then January 19th is day 1. Counting back from January 19th, the 14 day period is January 6 through January 19. If an inpatient discharge date falls on any date in that period or on the admission day itself (January 20), it is eligible to be reported on the claim.

If more than one inpatient discharge occurs during the 14 day period, the HHA reports only the most recent applicable discharge date. Claims reporting more than one of any combination of occurrence codes 61 and 62 will be returned to the provider for correction.

Conditional - The HHA enters any other NUBC approved code to describe occurrences that apply to the claim.

Occurrence Span Code and Dates

Conditional - The HHA enters any NUBC approved Occurrence Span code to describe occurrences that apply to the claim. Reporting of occurrence span code 74 is not required to show the dates of an inpatient admission.

Value Codes and Amounts

Required - Home health payments must be based upon the site at which the beneficiary is served. For certain dates of service when required by law, payments may be further adjusted if the site is in a rural CBSA or rural county. For periods of care in which the beneficiary's site of service changes from one CBSA or county to another within the period, HHAs should submit the CBSA code or State and County code corresponding to the site of service at the end of the period.

Provider-submitted codes:

Code	Title	Definition
61	Location Where Service is Furnished (HHA and Hospice)	HHAs report the Core Based Statistical Area (CBSA) number (or rural state code) of the location where the home health or hospice service is delivered. The HHA reports the number in dollar portion of the form locator right justified to the left of the dollar/cents delimiter, add two zeros to the cents field if no cents.
85	County Where Service is Rendered	Where required by law or regulation, report the Federal Information Processing Standards (FIPS) State and County Code of the place of residence where the home health service is delivered.

Medicare-applied codes: The following codes are added during processing and may be visible in the A/B MAC (HHH)'s online claim history. They are never submitted by the HHA.

Code	Title	Definition
17	Outlier Amount	The amount of any outlier payment returned by the Pricer with this code. A/B MACs (HHH) always place condition code 61 on the claim along with this value code.
62	HH Visits - Part A	The number of visits determined by Medicare to be payable from the Part A trust fund to reflect the shift of payments from the Part A to the Part B trust fund as mandated by §1812 (a)(3) of the Social Security Act.
63	HH Visits - Part B	The number of visits determined by Medicare to be payable from the Part B trust fund to reflect the shift of payments from the Part A to the Part B trust fund as mandated by §1812 (a)(3) of the Social Security Act.
64	HH Reimbursement - Part A	The dollar amounts determined to be associated with the HH visits identified in a value code 62 amount. This Part A payment reflects the shift of payments from the Part A to the Part B trust fund as mandated by §1812 (a)(3) of the Social Security Act.
65	HH Reimbursement - Part B	The dollar amounts determined to be associated with the HH visits identified in a value code 63 amount. This Part B payment reflects the shift of payments from the Part A to the Part B trust fund as mandated by §1812 (a)(3) of the Social Security Act.

Code	Title	Definition
QF	Late-filed NOA penalty amount	The dollar amount that the claim payment was reduced due to the NOA being filed more than 5 days after the HH From date.
QV	Value-based purchasing adjustment amount	The dollar amount of the difference between the HHA's value-based purchasing adjusted payment and the payment amount that would have otherwise been made. May be a positive or a negative amount.

If information returned from the CWF indicates all visits on the claim are Part A, the shared system must place value codes 62 and 64 on the claim record, showing the total visits and total PPS payment amount as the values, and send the claim to CWF with RIC code V.

If information returned from CWF indicates all visits on the claim are Part B, the shared system must place value codes 63 and 65 on the claim record, showing the total visits and total PPS payment amount as the values, and send the claim to CWF with RIC code W.

If information returned from CWF indicates certain visits on the claim are payable from both Part A and Part B, the shared system must place value codes 62, 63, 64, and 65 on the claim record. The shared system also must populate the values for code 62 and 63 based on the numbers of visits returned from CWF and prorate the total PPS reimbursement amount based on the numbers of visits to determine the dollars amounts to be associated with value codes 64 and 65. The shared system will return the claim to CWF with RIC code U.

Revenue Code and Revenue Description

Required

HH PPS claims must report a 0023 revenue code line which contains a HIPPS code. HHAs enter only one 0023 revenue code per claim in all cases.

Claims must also report all services provided to the beneficiary within the period of care. All services must be billed on one claim for the entire period. The A/B MAC (HHH) will return to the provider TOB 0329 when submitted without any visit charges.

Each service must be reported in line item detail. Each service visit (revenue codes 042x, 043x, 044x, 055x, 056x and 057x) must be reported as a separate line. Any of the following revenue codes may be used:

027x	Medical/Surgical Supplies (Also see 062x, an extension of 027x) Required detail: With the exception of revenue code 0274 (prosthetic and orthotic devices), only service units and a charge must be reported with this revenue code. If also reporting revenue code 0623 to separately identify specific wound care supplies, not just supplies for wound care patients, ensure that the charge amounts for revenue code 0623 lines are mutually exclusive from other lines for supply revenue codes reported on the claim. Report only nonroutine supply items in this revenue code or in 0623. Revenue code 0274 requires an HCPCS code, the date of service units and a charge amount. NOTE: Revenue Codes 0275 through 0278 are not used for Medicare billing on HH PPS claims.
042x	Physical Therapy Required detail: One of the physical therapy HCPCS codes defined below in the instructions for the HCPCS code field, the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.
043x	Occupational Therapy Required detail: One of the occupational therapy HCPCS codes defined below in the instructions for the HCPCS code field, the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.
044x	Speech-Language Pathology Required detail: One of the speech-language pathology HCPCS codes defined below in the instructions for the HCPCS code field, the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.
055x	Skilled Nursing Required detail: One of the skilled nursing HCPCS codes defined below in the instructions for the HCPCS code field, the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.

056x	Medical Social Services Required detail: The medical social services HCPCS code defined below in the instructions for the HCPCS code field, the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.
057x	Home Health Aide (Home Health) Required detail: The home health aide HCPCS code defined below in the instructions for the HCPCS code field, the date of service, service units which represent the number of 15 minute increments that comprised the visit, and a charge amount.

NOTE: A/B MACs (HHH) will return claims to the provider if revenue codes 058x or 059x are submitted with covered charges on Medicare home health claims. They also return to the provider if revenue code 0624, investigational devices is reported on HH claims

Revenue Codes for Optional Billing of DME

Billing of DME provided in the period of care is not required on the HH PPS claim. Home health agencies retain the option to bill these services to their A/B MAC (HHH) processing home health claims or to have the services provided under arrangement with a supplier that bills these services to the DME MAC. Agencies that choose to bill DME services on their HH PPS claims must use the revenue codes below. These services will be paid separately in addition to the HH PPS amount, based on the applicable Medicare fee schedule. For additional instructions for billing DME services see chapter 20 of this manual.

0274	Prosthetic/Orthotic Devices Required detail: The applicable HCPCS code for the item, a date of service, a number of service units, and a charge amount.
029x	Durable Medical Equipment (DME) (Other Than Renal) Required detail: The applicable HCPCS code for the item, a date of service indicating the purchase date or the beginning date of a monthly rental, a number of service units, and a charge amount. Monthly rental items should be reported with a separate line for each month's rental and service units of one. Revenue code 0294 is used to bill drugs/supplies for the effective use of DME.

060x	Oxygen (Home Health) Required detail: The applicable HCPCS code for the item, a date of service, a number of service units, and a charge amount.

Revenue Code for Optional Reporting of Wound Care Supplies

0623	Medical/Surgical Supplies - Extension of 027x Required detail: Only service units and a charge must be reported with this revenue code. If also reporting revenue code 027x to identify nonroutine supplies other than those used for wound care, the HHA must ensure that the charge amounts for the two revenue code lines are mutually exclusive.

HHAs may voluntarily report a separate revenue code line for charges for nonroutine wound care supplies, using revenue code 0623. Notwithstanding the standard abbreviation "surg dressings," HHAs use this code to report charges for ALL nonroutine wound care supplies, including but not limited to surgical dressings.

Pub. 100-02, Medicare Benefit Policy Manual, chapter 7, defines routine vs. nonroutine supplies. HHAs use that definition to determine whether any wound care supply item should be reported in this line because it is nonroutine.

HHAs can assist Medicare's future refinement of payment rates if they consistently and accurately report their charges for nonroutine wound care supplies under revenue center code 0623. HHAs should ensure that charges reported under revenue code 027x for nonroutine supplies are also complete and accurate.

HCPCS/Accommodation Rates/HIPPS Rate Codes

Required - On the 0023 revenue code line, the HHA may submit the HIPPS code they expect will be used for payment if they choose to run grouping software at their site for internal accounting purposes. If not, they may submit any valid HIPPS code in order to meet this requirement.

HHAs enter only one HIPPS code per claim in all cases. Claims submitted with additional HIPPS codes will be returned to the provider.

Medicare will determine the appropriate HIPPS code for payment based on claims and OASIS data and will replace the provider-submitted HIPPS code as necessary. If the HIPPS code further changes based on medical review or other processes, the code used for payment is recorded in the APC-HIPPS field of the electronic claim record.

For revenue code lines other than 0023, the HHA reports HCPCS codes as appropriate to that revenue code. *The G- and Q- HCPCS codes listed below are for use by HHAs on*

Type of Bill 032x only. Claims with these HCPCS codes will be returned to the provider if submitted with Type of Bill 034x.

To report HH visits, the HHA reports one of the following HCPCS codes to represent a visit by each HH care discipline:

Physical Therapy (revenue code 042x)

G0151 Services performed by a qualified physical therapist in the home health or hospice setting, each 15 minutes.

G0157 Services performed by a qualified physical therapist assistant in the home health or hospice setting, each 15 minutes.

G0159 Services performed by a qualified physical therapist, in the home health setting, in the establishment or delivery of a safe and effective physical therapy maintenance program, each 15 minutes.

G2168 Services performed by a physical therapist assistant in the home health setting in the delivery of a safe and effective physical therapy maintenance program, each 15 minutes.

Occupational Therapy (revenue code 043x)

G0152 Services performed by a qualified occupational therapist in the home health or hospice setting, each 15 minutes.

G0158 Services performed by a qualified occupational therapist assistant in the home health or hospice setting, each 15 minutes.

G0160 Services performed by a qualified occupational therapist, in the home health setting, in the establishment or delivery of a safe and effective occupational therapy maintenance program, each 15 minutes.

G2169 Services performed by an occupational therapist assistant in the home health setting in the delivery of a safe and effective occupational therapy maintenance program, each 15 minutes.

Speech-Language Pathology (revenue code 044x)

G0153 Services performed by a qualified speech-language pathologist in the home health or hospice setting, each 15 minutes.

G0161 Services performed by a qualified speech-language pathologist, in the home health setting, in the establishment or delivery of a safe and effective speech-language pathology maintenance program, each 15 minutes.

Note that modifiers indicating services delivered under a therapy plan of care (modifiers GN, GO or GP) are not required on HH PPS claims.

Skilled Nursing (revenue code 055x)

General skilled nursing:

G0299 Direct skilled nursing services of a registered nurse (RN) in the home health or hospice setting

G0300 Direct skilled nursing of a licensed practical nurse (LPN) in the home health or hospice setting.

Care plan oversight:

G0162 Skilled services by a licensed nurse (RN only) for management and evaluation of the plan of care, each 15 minutes (the patient's underlying condition or complication requires an RN to ensure that essential non-skilled care achieves its purpose in the home health or hospice setting).

G0493 Skilled services of a registered nurse (RN) for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting).

G0494 Skilled services of a licensed practical nurse (LPN) for the observation and assessment of the patient's condition, each 15 minutes (the change in the patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment in the home health or hospice setting).

Training:

G0495 Skilled services of a registered nurse (RN), in the training and/or education of a patient or family member, in the home health or hospice setting, each 15 minutes.

G0496 Skilled services of a licensed practical nurse (LPN), in the training and/or education of a patient or family member, in the home health or hospice setting, each 15 minutes.

Medical Social Services (revenue code 056x)

G0155 Services of a clinical social worker under a home health plan of care, each 15 minutes.

Home Health Aide (revenue code 057x)

G0156 Services of a home health aide under a home health plan of care, each 15 minutes.

Regarding all skilled nursing and skilled therapy visits

In the course of a single visit, a nurse or qualified therapist may provide more than one of the nursing or therapy services reflected in the codes above. HHAs must not report more than one G-code for each visit regardless of the variety of services provided during the visit. In cases where more than one nursing or therapy service is provided in a visit, the HHA must report the G-code which reflects the service for which the clinician spent most of his/her time.

For instance, if direct skilled nursing services are provided, and the nurse also provides training/education of a patient or family member during that same visit, Medicare would expect the HHA to report the G-code which reflects the service for which most of the time was spent during that visit. Similarly, if a qualified therapist is performing a therapy service and also establishes a maintenance program during the same visit, the HHA should report the G-code that reflects the service for which most of the time was spent during that visit. In all cases, however, the number of 15-minute increments reported for the visit should reflect the total time of the visit.

Telehealth Service Reporting

Beginning on or after January 1, 2023, HHAs may voluntarily report the use of telecommunications technology in the provision of home health services on claims. This information is required on home health claims beginning on July 1, 2023. HHAs shall submit the use of telecommunications technology when furnishing home health services, on the home health claim via three G-codes.

G0320: home health services furnished using synchronous telemedicine rendered via a real-time two-way audio and video telecommunications system

G0321: home health services furnished using synchronous telemedicine rendered via telephone or other real-time interactive audio-only telecommunications system

G0322: the collection of physiologic data digitally stored and/or transmitted by the patient to the home health agency (i.e., remote patient monitoring).

HHAs shall submit services furnished via telecommunications technology in line item detail and each service must be reported as a separately dated line under the appropriate revenue code for each discipline furnishing the service. Two occurrences of G0320 or G0321 on the same day for the same revenue code shall be reported as separate line items.

The use of remote patient monitoring that spans a number of days shall be reported as a single G0322 line item reporting the beginning date of monitoring and the number of

days of monitoring in the units field. If more than one discipline is using the remote monitoring information during the billing period, the HHA may choose which revenue code to report on the remote monitoring line item.

Claims with no billable visits are not submitted to Mediare, including claims for billing periods where only telehealth services are provided.

Site of Service Reporting

HHAs must report where home health services were provided. The following codes are used for this reporting:

Q5001: Hospice or home health care provided in patient's home/residence

Q5002: Hospice or home health care provided in assisted living facility

Q5009: Hospice or home health care provided in place not otherwise specified

The location where services were provided must always be reported along with the first visit reported on the claim. In addition to reporting a visit line using the G codes as described above, HHAs must report an additional line item with the same revenue code and date of service, reporting one of the three Q codes (Q5001, Q5002, and Q5009), one unit and a nominal covered charge (e.g., a penny). If the location where services were provided changes during the period of care, the new location should be reported with an additional line corresponding to the first visit provided in the new location.

Disposable Negative Pressure Wound Therapy Services

Effective for claims with statement covers Through dates on or after January 1, 2024, Medicare makes a separate payment amount for a disposable negative pressure wound therapy (NPWT) device for a patient under a home health plan of care. Payment is equal to the supply price used to determine the relative value for the service under the Medicare Physician Fee Schedule (as of January 1, 2022) for the applicable disposable device and updated by the consumer price index for all urban consumers minus the productivity adjustment for each future year.

Disposable NPWT services are billed using the following HCPCS code:

- *A9272 - wound suction, disposable, includes dressing, all accessories and components, any type, each.*

The HHA reports the HCPCS code with revenue code 027x (other than 0274), units representing the number of disposable devices provided during the billing period and a charge amount. Since Medicare payment no longer includes the services of the practitioner applying the device, revenue codes 042x, 043x or 0559 are not used for dNPWT HCPCS codes on Type of Bill 032x.

Modifiers

If the NOA that corresponds to a claim was filed late and the HHA is requesting an exception to the late-filing penalty (see section 10.1.10.3), append modifier KX to the HIPPS code reported on the revenue code 0023 line.

Service Date

Required - For initial periods of care, the HHA reports on the 0023 revenue code line the date of the first covered visit provided during the period. Claims and provider-submitted adjustments where the Admission Date and From Date match but the 0023 revenue code line date does not also match are returned to the provider. Contractor-submitted adjustments are excluded from this edit.

For subsequent periods, the HHA reports on the 0023 revenue code the date of the first visit provided during the period, regardless of whether the visit was covered or non-covered.

For other line items detailing all services within the period, the HHA reports service dates as appropriate to that revenue code. For service visits that begin in 1 calendar day and span into the next calendar day, report one visit using the date the visit ended as the service date.

When the claim Admission Date matches the Statement Covers "From" Date, Medicare systems ensure that the Service Date on the 0023 revenue code line also matches these dates.

Service Units

Required - Transaction standards require the reporting of a number greater than zero as the units on the 0023 revenue code line. However, Medicare systems will disregard the submitted units in processing the claim. For line items detailing all services within the period, the HHA reports units of service as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined above under Revenue Codes.

For the revenue codes that represent home health visits (042x, 043x, 044x, 055x, 056x, and 057x), the HHA reports as service units a number of 15 minute increments that comprise the time spent treating the beneficiary. Time spent completing the OASIS assessment in the home as part of an otherwise covered and billable visit and time spent updating medical records in the home as part of such a visit may also be reported.

Visits of any length are to be reported, rounding the time to the nearest 15-minute increment. If any visits report over 96 units (over 24 hours) on a single line item, Medicare systems return the claim returned to the provider.

Covered and noncovered increments of the same visit must be reported on separate lines. This is to ensure that only covered increments are included in the per-unit based calculation of outlier payments.

Telehealth services with HCPCS codes G0320 or G0321 are reported with units of 1.

Total Charges

Required - The HHA must report zero charges on the 0023 revenue code line (the field must contain zero).

For line items detailing all services within the period of care, the HHA reports charges as appropriate to that revenue code. Coding detail for each revenue code under HH PPS is defined above under Revenue Codes. Charges may be reported in dollars and cents (i.e., charges are not required to be rounded to dollars and zero cents). Medicare claims processing systems will not make any payments based upon submitted charge amounts.

Non-covered Charges

Required – The HHA reports the total non-covered charges pertaining to the related revenue code here. Examples of non-covered charges on HH PPS claims may include:

- Visits provided exclusively to perform OASIS assessments
- Visits provided exclusively for supervisory or administrative purposes
- Therapy visits provided prior to the required re-assessments

Payer Name

Required - See chapter 25.

Release of Information Certification Indicator

Required - See chapter 25.

National Provider Identifier – Billing Provider

Required - The HHA enters their provider identifier.

Insured's Name

Required only if MSP involved. See Pub. 100-05, Medicare Secondary Payer Manual.

Patient's Relationship To Insured

Required only if MSP involved. See Pub. 100-05, Medicare Secondary Payer Manual.

Insured's Unique Identifier

Required only if MSP involved. See Pub. 100-05, Medicare Secondary Payer Manual.

Insured's Group Name

Required only if MSP involved. See Pub. 100-05, Medicare Secondary Payer Manual.

Insured's Group Number

Required only if MSP involved. See Pub. 100-05, Medicare Secondary Payer Manual.

Treatment Authorization Code

Conditional - Treatment authorization codes are not required on all claims. The HHA submits a code in this field only if the period is subject to Pre-Claim Review. In that case, the required tracking number is submitted in the first position of the field in all submission formats.

Document Control Number (DCN)

Required - If submitting an adjustment (TOB 0327) to a previously paid HH PPS claim, the HHA enters the control number assigned to the original HH PPS claim here.

Employer Name

Required only if MSP involved. See Pub. 100-05, Medicare Secondary Payer Manual.

Principal Diagnosis Code

Required - The HHA enters the ICD code for the principal diagnosis. The code must be reported according to Official ICD Guidelines for Coding and Reporting, as required by the HIPAA. The code must be the full diagnosis code, including all five digits for ICD-9-CM or all seven digits for ICD-10 CM where applicable. Where the proper code has fewer than the maximum number of digits, the HHA does not fill it with zeros.

Medicare systems may return claims to the provider when the principal diagnosis code is not sufficient to determine the HHRG assignment under the PDGM.

The ICD code and principle diagnosis used for payment grouping is determined from claim coding rather than the OASIS assessment. As a result, the claim and OASIS diagnosis codes are not expected to match in all cases.

Typically, the codes will match between the first claim in an admission and the start of care (Reason for Assessment –RFA 01) assessment and claims corresponding to recertification (RFA 04) assessments. Second 30-day claims in any 60-day period will

not necessarily match the OASIS assessment. When diagnosis codes change between one 30-day claim and the next, there is no absolute requirement for the HHA to complete an 'other follow-up' (RFA 05) assessment to ensure that diagnosis coding on the claim matches to the assessment. However, the HHA would be required to complete an 'other follow-up' (RFA 05) assessment when such a change would be considered a major decline or improvement in the patient's health status.

Other Diagnosis Codes

Required - The HHA enters the full diagnosis codes for additional conditions if they coexisted at the time of the establishment of the plan of care. These codes may not duplicate the principal diagnosis as an additional or secondary diagnosis.

In listing the diagnoses, the HHA places them in order to best reflect the seriousness of the patient's condition and to justify the disciplines and services provided in accordance with the Official ICD Guidelines for Coding and Reporting. The sequence of codes should follow ICD guidelines for reporting manifestation codes. Medicare does not have any additional requirements regarding the reporting or sequence of the codes beyond those contained in ICD guidelines.

The claim and OASIS diagnosis codes may vary as described under Principal Diagnosis.

Diagnosis codes that reflect the patient's condition as of the start of a period of care are reflected on the claim for the current period of care. Diagnosis codes that reflect a change in the patient's condition during a period of care should be reflected on the claim for the next period.

Attending Provider Name and Identifiers

Required - The HHA enters the name and national provider identifier (NPI) of the attending physician who signed the plan of care.

Other Provider (Individual) Names and Identifiers

Required - The HHA enters the name and NPI of the physician who certified/re-certified the patient's eligibility for home health services.

NOTE: Both the attending physician and other provider fields should be completed unless the patient's designated attending physician is the same as the physician who certified/re-certified the patient's eligibility. When the attending physician is also the certifying/re-certifying physician, only the attending physician is required to be reported.

Remarks

Conditional – If the NOA that corresponds to a claim was filed late and the HHA is requesting an exception to the late-filing penalty (see section 10.1.10.3), enter information supporting the exception category that applied to the NOA.

The HHA shall provide sufficient information in the Remarks section of its claim to allow the contractor to research the case. If the remarks are not sufficient, Medicare contractors shall request documentation. Documentation should consist of printouts or screen images of any Medicare systems screens that contain the information shown above.

Medicare contractors shall not grant exceptions if:
• the HHA can correct the NOA without waiting for Medicare systems actions
• the HHA submits a partial NOA to fulfill the timely-filing requirement, or
• HHA with multiple provider identifiers submit the identifier of a location that did not actually provide the service

In the great majority of cases, the five day timely filing period allows enough time to submit NOAs on a day when Medicare systems are available (i.e. the period allows for ("dark days"). Additionally, the receipt date is typically applied to the NOA immediately upon submission to Medicare systems, so subsequent dark days would not affect the determination of timeliness. However, if the HHA can provide documentation showing an NOA is submitted on the day before a dark day period and the NOA does not receive a receipt date until the day following the dark days, the contractor shall grant an exception to the timely filing requirement. CMS expects these cases to be very rare.

Remarks are otherwise required only in cases where the claim is cancelled or adjusted. adjusted.

40.5 – RESERVED
(Rev. 4312, Issued: 05-23-19, Effective: 01-01-20, Implementation: 08-16-19)

50 - Beneficiary-Driven Demand Billing Under HH PPS
(Rev. 10758; Issued: 05-11-21; Effective: 01-01-22; Implementation: 08-11-21)

Demand billing is a procedure through which beneficiaries can request Medicare payment for services that: (1) their HHAs advised them were not medically reasonable and necessary, or that (2) they failed to meet the homebound, intermittent or noncustodial care requirements, and therefore would not be reimbursed if billed. The HHA must inform the beneficiary of this assessment in an Advance Beneficiary Notice of Noncoverage (ABN), which also must be signed by the beneficiary or appropriate representative. Instructions for the ABN are found in chapter 30 of this manual.

Beneficiaries pay out of pocket or third party payers cover the services in question, but HHAs in return, upon request of the beneficiary, are required to bill Medicare for the disputed services. If, after its review, Medicare decides some or all the disputed services received on the “demand bill” are covered and pays for them, the HHA would refund the previously collected funds for these services. If the Medicare determination upholds the HHA’s judgment that the services were not medically reasonable and necessary, or that the beneficiary failed to meet the homebound or intermittent care requirements, the HHA

keeps the funds collected, unless the A/B MAC (HHH) determines the ABN notification was not properly executed, or some other factor changed liability for payment of the disputed services back to the HHA.

A. Interval of Billing

The Medicare payment unit for home care under the home health prospective payment system (HH PPS) is a period of care, usually 30 days in length. A Notice of Admission (NOA) must be submitted for a beneficiary before any claims can be processed. A claim is submitted for every 30 days of HH services. This does not change in demand bill situations.

B. Timeliness of Billing

Medicare requests that HHAs submit demand bills promptly. Timely filing requirements apply to HH PPS claims in the same manner as other claims (see chapter 1 for information on timely filing). Medicare has defined "promptly" for HH PPS to mean submission at the end of the period of care in question. The beneficiary must also be given either a copy of the claim or a written statement of the date the claim was submitted.

C. Claim Requirements

HH PPS claims, including demand bills, are submitted with TOB 0329, and provide all other information required on that claim for the HH PPS period of care, including all visit-specific detail. The HHA must NOT use TOB 0320 when submitting a demand bill. The HHA must report condition code "20" and the services in dispute shown as noncovered line items. Demand bills may be submitted with all noncovered charges. Provision of this additional information assures medical review of the demand bill.

Cases may arise in which the services in dispute are visits for which an HHA has physician's orders, but the duration of the visits exceeds Medicare coverage limits. However, the portion of these visits that is not covered by Medicare may be covered by another payer (e.g., an 8-hour home health aide visit in which the first 2 hours may be covered by Medicare and the remaining 6 hours may be covered by other insurance). In such cases, HHAs must submit these visits on demand bills as two line items. One line will represent the portion potentially covered by Medicare with a covered charge amount and units reporting the Medicare-covered visit time. The second line will represent the portion to be submitted for consideration by other insurance with a noncovered charge amount and units reporting non-Medicare visit time.

Cases may also arise in which a State Medicaid program requests the demand bill on the beneficiary's behalf regarding services which have been billed to Medicaid. In these cases, the dates of service for which the State requests the demand bill may not

correspond exactly to the periods billed to Medicare. These cases require special instructions:

Requests regarding services not expected to be billed to Medicare:

A Medicare-Medicaid dually-eligible patient may be admitted to home care with the expectation that no services will be billed to Medicare. Later, the State may request demand bills beginning during the course of that care. This may occur when requests correspond to a calendar year. For example, the patient may be admitted in December and the request for demand bills is effective January 1. In this case, the HHA should submit a demand bill to Medicare with period of care dates that began in December. All services should be submitted as non-covered line items. As with any demand bill, condition code 20 should be reported on this claim.

Request applies to services immediately following Medicare discharge:

A dually-eligible patient may be discharged from Medicare home health services before the end of a 30-day period of care due to the patient meeting their treatment goals. The patient may remain under the care of the HHA receiving services billed to Medicaid. States may vary in their requirements for a new Start of Care OASIS assessment in these cases.

If the State requesting a demand bill for the services within the original 30-day period of care does not require a new OASIS assessment, the HHA should submit an adjustment to their previously paid Medicare claim, using TOB 0327. The HHA should add condition code 20 to the adjustment claim, change the statement "Through" date to reflect the full 30-day period and add the services provided during the demand bill request period as non-covered line items. The HHA should then submit claims with condition code 20 and all non-covered line items for any periods of continuous care within the demand bill request period.

If the State requesting a demand bill for the services within the 30-day period of care requires a new OASIS assessment, the HHA should submit an NOA and submit claims with condition code 20 as they would for any other demand bill situation. When Medicare receives the NOA for the demand billed episode it will cause a partial period payment adjustment to apply to the prior period. Medicare cannot presume that the demand billed period will or will not be covered based on the NOA. If the claim for the demand billed period is later reviewed and found to be entirely non-covered, Medicare systems will automatically adjust the prior period to restore the appropriate full episode payment.

D. Favorable Determinations and Medicare Payment

Results of Medicare determinations favorable to the party requesting the demand bill will not necessarily result in increased Medicare payment. In such cases, and even if a favorable determination is made but payment does not change, HHAs will still refund any

monies collected from beneficiaries or other payers for services previously thought not medically necessary under Medicare. Medicare payment will change only with the addition of covered visits if one or more of the following conditions apply:

- An increase in the number of overall visits that either:

    1. Changes payment from a low-utilization payment adjustment to a full period payment; or

    2. Results in the period of care meeting the threshold for outlier payment.

- A favorable ruling on a demand bill adds days to a claim paid a partial period payment adjustment.

If a favorable determination is made, A/B MACs (HHH) will assure pricing of the claim occurs after medical review so that claims also serving as demand bills receive appropriate payment.

E. Appeals

Appeal of Medicare determinations made on HH PPS claims also serving as demand bills is accomplished by appealing the HH PPS claim. Such appeals are done in accordance with regulations stipulating appeals rights for Medicare home health claims.

F. Specific Demand Billing Scenarios

1. Independent Assessment -- Billing questions relative to the ABN and home health assessments. With regard to payment liability for the assessment itself, the assessment is a non-covered service that is not a Medicare benefit and is never separately payable by Medicare. In all such cases, a choice remains: The provider may or may not decide to hold the beneficiary liable, and Medicare cannot specify which is appropriate because the service at issue is outside Medicare's scope.

If a decision is made to hold a beneficiary liable for just the assessment, Medicare providers must be in compliance with the home health Conditions of Participation (COPs), as follows:

> 42 CFR 484.10.e (1) The patient has the right to be advised, before care is initiated, of the extent to which payment for the HHA services may be expected from Medicare or other sources, and the extent to which payment may be required from the patient. Before care is initiated, the HHA must inform the patient, orally and in writing, of: (i) The extent to which payment may be expected from Medicare, Medicaid or any other Federally funded or aided program known to the HHA; (ii) The charges for services that will not be covered by Medicare; and (iii) The charges that the individual has to pay.

Therefore, while no notice may be required if the provider chooses to be liable, the conditions state a notice is required if the beneficiary is to be held liable, and must be delivered prior to the service in question. ABNs can be used for this purpose.

2. Billing in Excess of the Benefit. In some states, the Medicaid program will cover more hours of care in a week than the Medicare benefit. Therefore, an HHA may be billing hours/visits in excess of the benefit during a Medicare home health period of care for a dually eligible beneficiary. Since the care delivered in excess of the benefit is not part of the benefit, and does not affect the amount of Medicare's prospectively set payment, there is no dispute as to liability, and an ABN is not required unless a triggering event occurs; that is, care in excess of the benefit is not a triggering event in and of itself requiring an ABN. Billing services in excess of the benefit is discussed in C in this section.

3. One-Visit Periods. Since intermittent skilled nursing care is a requirement of the Medicare home health benefit, questions often arise as to the billing of one-visit periods of care. Medicare claims systems will process such billings, but these billings should only be done when some factor potentially justifies the medical necessity of the service relative to the benefit.

Many of these cases do not even need to be demand billed, because coverage is not in doubt, since physician orders called for delivery of the benefit. When the beneficiary dies after only one visit is a clear-cut example. When physician orders called for additional services, but the beneficiary died before more services could be delivered, the delivery of only one visit is covered. The death is indicated on the claim with use of patient status code 20. Other cases in which orders called for additional services, but circumstances prevented delivery of more than one service by the HHA, are also appropriately billed to Medicare in the same fashion.

There may be rare cases where, even though orders do not clearly indicate the need for additional services, the HHA feels delivery of the service is medically justified by Medicare's standard, and should be covered. In such situations, when doubt exists, an HHA should still give the beneficiary an ABN if a triggering event has occurred, explaining Medicare may not cover the service, and then demand bill the service in question.

No billing is required when there is no dispute that the one service called for on the order does not meet the requirements for the Medicare home health benefit, or is not medically necessary. However, there are options for billing these non-covered services as discussed in chapter 1, section 60 of this manual. Note the COPs may require notification in this situation if the beneficiary is to be held liable, as discussed in number 1, immediately above.

60 - No Payment Billing

(Rev.11341; Issued:04-07-22; Effective: 10-01-22; Implementation: 10-03-22)

Home health agencies may seek denials for entire claims from Medicare in cases where a provider knows all services will not be covered by Medicare. Such denials are usually sought because of the requirements of other payers for providers to obtain Medicare denial notices before they will consider providing additional payment. Such claims are often referred to as no-payment bills or billings for denial notice.

A. Submission and Processing

In order to submit a no-payment bill to Medicare under HH PPS, providers must use TOB 0320, and condition code 21. Claims with condition code 21 and any other TOB will be returned to the provider for correction. A Notice of Admission (TOB 032A) is not required before the submission of a claim with TOB 0320 and condition code 21.

The statement dates on the claim should conform to the billing period they plan to submit to the other payer, insuring that no future date is reported. Providers must also submit the charge for each line item on the claim as a non-covered charge.

In order for these claims to process through the subsequent HH PPS edits in the system, providers are instructed to submit a 0023 revenue line on the claim. If no OASIS assessment was done or if the HHA chooses not to perform payment grouping before submitting the claim, report any valid HIPPS code.

The claim must meet other minimum Medicare requirements. If an OASIS assessment was done and the HHA chooses to perform payment grouping for their internal accounting purposes, the HHA may report the resulting HIPPS code.

B. Simultaneous Covered and Non-Covered Services

In some cases, providers may need to obtain a Medicare denial notice for non-covered services delivered in the same period as covered services that are part of an HH PPS period of care. In such cases, the provider should submit a non-payment bill according to the instructions above for the non-covered services alone, AND submit the appropriate NOA and claim for the HH PPS period of care. The period billed under the HH PPS claim and the non-payment bill should be the same. Medicare standard systems and the CWF will allow such duplicate claims to process when all services on one claim are non-covered.

C. Custodial Care under HH PPS, or Termination of the Benefit during a Period

In certain cases, Medicare allows the use of no payment claims in association with an ABN involving custodial care and termination of a benefit during a period of care. This does not apply to cases in which a determination is being requested as to the beneficiary's

homebound status at the beginning of a period of care; there an ABN must be used assuming a triggering event occurs (i.e., the initiation of completely noncovered care). However, in cases where the HH plan of care prescribes only custodial care, or if the benefit has terminated during a previous period, and the physician, beneficiary, and provider are all in agreement the benefit has terminated or does not apply, home health agencies (HHAs) can use:

1. The ABN for notification of the beneficiary, and,

2. A condition code 21 no-payment claim to bill all subsequent services.

70 - HH PPS Pricer Program
(Rev. 1, 10-01-03)
HH-475.4

70.1 - General
(Rev. 10758; Issued: 05-11-21; Effective: 01-01-22; Implementation: 08-11-21)

Home health services billed on TOB 032x are reimbursed based on calculations made by the HH Pricer. The HH Pricer is a module within Medicare claims processing systems. The HH Pricer makes all payment calculations applicable under HH PPS, including claim payments for full periods of care, and all payment adjustments, including low utilization payment adjustments (LUPAs), partial period payment adjustments, and outlier payments.

Medicare claims processing systems send an input record to Pricer for all claims with covered visits, and Pricer will return an output record to the shared systems. The following sections describe the elements of HH PPS claims that are used in the HH PPS Pricer and the logic that is used to make payment determinations. No part of the Pricer logic is required to be incorporated into an HHA's billing system in order to bill Medicare. The following is presented for A/B MACs (HHH) and as information for the HHAs, in order to help HHAs understand their HH PPS payments and how they are determined.

70.2 - Input/Output Record Layout
(Rev. 10919, Issued:08-06-21, Effective:01-01-22, Implementation: 01-03-22)

The required data and format for the HH Pricer input/output record for periods of care beginning on or after January 1, 2021 are shown below:

File Position	Format	Title	Description
1-10	X(10)	NPI	Input item: The National Provider Identifier, copied from the claim form.

File Position	Format	Title	Description
11-22	X(12)	HIC	Input item: The Health Insurance Claim number of the beneficiary, copied from the claim form.
23-28	X(6)	PROV-NO	Input item: The six-digit CMS certification number, copied from the claim form.
29	X	INIT-PAY-QRP-INDICATOR	Input item: A single character to indicate whether payment should be reduced under the Quality Reporting Program. Medicare systems move this value from field 18 of the provider specific file. Valid values: 0 = Make normal percentage payment 2 = Make final payment reduced by 2%
30-35	9V9(5)	PROV-VBP-ADJ-FAC	Input item: Medicare systems move this information from from field 30 of the provider specific file.
36-45	9(8)V99	PROV-OUTL-PAY-TOT	Input item: The total amount of outlier payments that have been made to this HHA for periods of care ending during the current calendar year.
46-56	9(9)V99	PROV-PAYMENT-TOTAL	Input item: The total amount of HH PPS payments that have been made to this HHA for periods of care ending during the current calendar year.
57-59	X(3)	TOB	Input item: The type of bill code, copied from the claim form.
60-64	X(5)	CBSA	Input item: The core based statistical area (CBSA) code, copied from the value code 61 amount on the claim form.
65-69	X(5)	COUNTY-CODE	Input item: The FIPS State and County Code copied from the value code 85 amount on the claim form.
70-77	X(8)	SERV-FROM-DATE	Input item: The statement covers period “From” date, copied from the claim form. Date format must be CCYYMMDD.
78-85	X(8)	SERV-THRU DATE	Input item: The statement covers period “through” date, copied from the claim form. Date format must be CCYYMMDD.
86-93	X(8)	ADMIT-DATE	Input item: The admission date, copied from claim form. Date format must be CCYYMMDD.
94	X	LUPA-SRC-ADM	Input Item: Medicare systems set this indicator to ‘B’ when condition code 47 is present on the claim. The indicator is set to ‘1’ in all other cases.
95	X	ADJ-IND	Input Item: Medicare systems set the adjustment indicator to ‘2’ when a LUPA add-on claim is identified as not being the first or only period in a sequence. The indicator is set to ‘0’ in all other cases.

File Position	Format	Title	Description
96	X	PEP-IND	Input item: A single Y/N character to indicate if a claim must be paid a partial period payment adjustment. Medicare claims processing systems set a Y if the patient discharge status code of the claim is 06. An N is set in all other cases.
97-101	X(5)	HRG-INPUT-CODE	Input item: Medicare claims processing systems must copy the HIPPS code from the 0023 revenue code line.
102-104	9(3)	HRG-NO-OF - DAYS	Input item: A number of days calculated by the shared systems for each HIPPS code. The number is determined by the span of days from and including the first line item service date provided under that HIPPS code to and including the last line item service date provided under that HIPPS code.
105-110	9(2)V9(4)	HRG-WGTS	Output item: The weight used by the Pricer to determine the payment amount on the claim.
111-119	9(7)V9(2)	HRG-PAY	Output item: The payment amount calculated by the Pricer for the HIPPS code.
120-123	X(4)	REVENUE - CODE	Input item: One of the six home health discipline revenue codes (042x, 043x, 044x, 055x, 056x, 057x). All six revenue codes must be passed by the Medicare claims processing systems even if the revenue codes are not present on the claim.
124-126	9(3)	REVENUE-QTY - COV-VISITS	Input item: A quantity of covered visits corresponding to each of the six revenue codes. Medicare claims processing systems must count the number of covered visits in each discipline on the claim. If the revenue codes are not present on the claim, a zero must be passed with the revenue code.
127-131	9(5)	REVENUE-QTY - OUTLIER-UNITS	Input item: The sum of the units reported on all covered lines corresponding to each of the six revenue codes. Medicare claims processing systems accumulate the number of units in each discipline on the claim, subject to a limit of 32 units per date of service. If any revenue code is not present on the claim, a zero must be passed with that revenue code.
132-139	9(8)	REVENUE-EARLIEST-DATE	Input item: The earliest line item date for the corresponding revenue code. Date format must be CCYYMMDD.

File Position	Format	Title	Description	
140-148	9(7)V9(2)	REVENUE - DOLL-RATE	Output item: The dollar rates used by the Pricer to calculate the payment for the visits in each discipline if the claim is paid as a LUPA.	
149-157	9(7)V9(2)	REVENUE - COST	Output item: The dollar amount determined by the Pricer to be the payment for the visits in each discipline if the claim is paid as a LUPA.	
158-166	9(7)V9(2)	REVENUE-ADD-ON-VISIT-AMT	Output item: The add-on amount to be applied to the earliest line item date with the corresponding revenue code. If revenue code 055x, then this is the national per-visit amount multiplied by 1.8451. If revenue code 042x, then this is the national per-visit amount multiplied by 1.6700. If revenue code 043x and the Through date is on or after January 1, 2022, then this is the national per-visit amount multiplied by 1.6700. If revenue code 044x, then this is the national per-visit amount multiplied by 1.6266.	
168-401	Defined above	Additional REVENUE data	Five more occurrences of all REVENUE related data defined above.	
402-403	9(2)	PAY-RTC	Output item: A return code set by Pricer to define the payment circumstances of the claim or an error in input data.	
			Payment return codes:	
			00	Final payment where no outlier applies
			01	Final payment where outlier applies
			02	Final payment where outlier applies, but is not payable due to limitation.
			03	Not used.
			04	Not used.
			05	Not used.
			06	LUPA payment only
			07	Not used.
			08	Not used.
			09	Final payment, partial period payment
			11	Final payment, partial period payment with outlier
			12	Not used.
			13	Not used.

File Position	Format	Title	Description	
			14	LUPA payment, add-on payment applies
			Error return codes:	
			10	Invalid TOB
			15	Invalid PEP days
			16	Invalid HRG days, greater than 30
			20	PEP indicator invalid
			25	Med review indicator invalid
			30	Invalid CBSA code
			31	Invalid/missing County Code
			35	Invalid Initial Payment Indicator
			40	Dates before January 2020 or invalid
			70	Invalid HRG code
			75	No HRG present in 1st occurrence
			80	Invalid revenue code
			85	No revenue code present on adjustment TOB
404-408	9(5)	REVENUE - SUM 1-6-QTY-ALL	Output item: The total number of visits used by the Pricer to determine if the claim must be paid as a LUPA. This amount will be the total of all the covered visit quantities input with all six HH discipline revenue codes.	
409-417	9(7)V9(2)	OUTLIER - PAYMENT	Output item: The outlier payment amount determined by the Pricer to be due on the claim in addition to any HRG payment amounts. Added to the claim as a value code 17 amount.	
418-426	9(7)V9(2)	TOTAL - PAYMENT	Output item: The total payment determined by the Pricer to be due on the claim.	
427-435	S9(7)V9(2)	VBP-ADJ-AMT	Output item: The HHVBP adjustment amount, determined by subtracting the HHVBP adjustment total payment from the HH PPS payment that would otherwise apply to the claim. Added to the claim as a value code QV amount.	
436-444	9(7)V9(2)	PPS-STD-VALUE	Output item: Standardized payment amount – the HH PPS payment without applying any provider-specific adjustments. Informational only. Subject to additional calculations before entered on the claim in PPS-STNDRD-VALUE field.	
445-452	X(8)	RECEIPT-DATE	Input item: The receipt date of the corresponding NOA for this claim. Date format must be CCYYMMDD.	

File Position	Format	Title	Description
453	X	OVERRIDE-IND	Input item: An indicator of whether an exception request to the late filing penalty has been granted by the MAC. Valid values: Y = Exception has been granted, no late filing penalty will be calculated N = No exception applies, calculate late filing penalty, if applicable.
454-462	9(7)V9(2)	LATE-SUB-PENALTY-AMT	Output item: The late submission penalty amount, determined by subtracting the total payment after the late submission penalty from the HH PPS payment that would otherwise apply to the claim. Added to the claim as a value code QF amount.
463-650	X(188)	FILLER	

Input records on claims must include all input items. Output records will contain all input and output items. If an output item does not apply to a particular record, Pricer will return zeroes.

The Medicare claims processing system will move the following Pricer output items to the claim record. The return code will be placed in the claim header. The HRG-PAY amount for the HIPPS code will be placed in the revenue code 0023 line. The OUTLIER-PAYMENT amount, if any, will be placed in a value code 17 amount. If the return code is 06 or 14 (indicating a low utilization payment adjustment), the Medicare claims processing system will apportion the REVENUE-COST amounts to the appropriate line items in order for the per-visit payments to be accurately reflected on the remittance advice. If the return code is 14, the Medicare claims processing system will apply the H-HHA-REVENUE-ADD-ON-VISIT-AMT to the earliest line item with the corresponding revenue code.

70.3 - RESERVED

(Rev. 10758; Issued: 05-11-21; Effective: 01-01-22; Implementation: 08-11-21)

70.4 - Decision Logic Used by the Pricer on Claims

(Rev. 10919, Issued:08-06-21, Effective:01-01-22, Implementation: 01-03-22)

On input records with TOB 329, 327, 32F, 32G, 32H, 32I, 32J, 32K, 32M, 32Q, 33Q or 32P (that is, all provider submitted claims and provider or A/B MAC (HHH) initiated adjustments), Pricer will perform the following calculations in the numbered order.

If the “SERV-FROM-DATE” is on or after January 1, 2020, the Pricer shall perform the following:

Prior to these calculations, determine the applicable Federal standard rate to apply by reading the value in "INIT-PAY-QRP-INDICATOR." If the value is 0, use the full standard rate in subsequent calculations. If the value is 2, use the standard rate which has been reduced by 2 percent due to the failure of the provider to report required quality data.

1. Low Utilization Payment Adjustment (LUPA) calculation.

   1.1 If the "REVENUE-SUM1-6-QTY-ALL" is less than the LUPA threshold associated with the "HRG-INPUT-CODE" (e.g. threshold is 6, sum is 5 or less), read the national standard per visit rates for each of the six "REVENUE-QTY-COV-VISITS" fields from the revenue code table for the calendar year in which the "SERV-THRU-DATE" falls. Multiply each quantity by the corresponding rate. Wage index adjust each value and report the payment in the associated "REVENUE-COST" field.

   1.2 If the following conditions are met, calculate an additional LUPA add-on payment:
   - the dates in the "SERV-FROM-DATE" and "ADMIT-DATE" fields match
   - the first position of the HIPPS code is a 1 or a 2
   - the value in "LUPA-SRC-ADM" is not a B AND
   - the value in "RECODE-IND" is not a 2.

   Compare the earliest line item dates for revenue codes 042x, 044x and 055x and select the revenue code with the earliest date.

   If the earliest date for revenue codes 042x, 043x (CY 2022 and after) or 044x match the revenue code 055x date, select revenue code 055x.

   If the earliest date for revenue codes 042x and 044x match and revenue code 055x is not present, select revenue code 042x.

   For claims with Through dates on or after January 1, 2022:

   If the earliest date for revenue codes 042x and 043x match and revenue code 055x is not present, select revenue code 042x.

   If the earliest date for revenue codes 043x and 044x match and revenue code 055x is not present, select revenue code 043x.

   1.3 Apply the appropriate LUPA add-on factor to the selected earliest dated line.

   - If revenue code 055x, multiply the national per-visit amount by 1.8451.

- If revenue code 042x, multiply the national per-visit amount by 1.6700.
- If revenue code 043x, multiply the national per-visit amount by 1.6700.
- If revenue code 044x, multiply the national per-visit amount by 1.6266.

Return the resulting payment amount in the "REVENUE-ADD-ON-VISIT-AMT" field.

1.4 Return the sum of all "REVENUE-COST" amounts and the "REVENUE-ADD-ON-VISIT-AMT" amount, if applicable, in the "TOTAL-PAYMENT" field. If the LUPA payment includes LUPA add-on amount, return 14 in the "PAY-RTC" field. Otherwise, return 06 in the "PAY-RTC" field. No further calculations are required.

1.5 If "REVENUE-SUM1-6-QTY-ALL" is greater than or equal to the LUPA threshold associated with the "HRG-INPUT-CODE", proceed to the HRG payment calculation in step 2.

2. HRG payment calculations.

2.1. If the "PEP-IND" is an N:

Find the weight for the "HRG-INPUT-CODE" from the weight table for the calendar year in which the "SERV-THRU-DATE" falls. Multiply the weight times the applicable period of care rate for the calendar year in which the "SERV-THRU-DATE" falls. The product is the case-mix adjusted rate.

Multiply the case-mix adjusted rate by the current labor-related percentage to determine the labor portion. Multiply the labor portion by the wage index corresponding to the "CBSA" field. Multiply the case-mix adjusted rate by the current nonlabor-related percentage to determine the nonlabor portion. Sum the labor and nonlabor portions. The sum is the wage index and case-mix adjusted payment for this HRG. Proceed to the outlier calculation in step 3.

2.2. If the "PEP-INDICATOR" is a Y:

Perform the calculation of the case-mix and wage index adjusted payment for the HRG amount, as in 3.1. Determine the proportion to be used to calculate this PEP by dividing the "PEP-DAYS" amount by 30. Multiply the case-mix and wage index adjusted payment by this proportion. The

result is the partial period payment due on the claim. Proceed to the outlier calculation in step 3.

3. Outlier calculation:

3.1. Wage index adjust the outlier fixed loss amount for the Federal fiscal year in which the "SERV-THRU-DATE" falls, using the CBSA code in the "CBSA" field. Add the resulting wage index adjusted fixed loss amount to the total dollar amount resulting from the HRG payment calculation. This is the outlier threshold for the period.

3.2. For each quantity in the six "REVENUE-QTY- OUTLIER-UNITS" fields, read the national standard per unit rates from the revenue code table for the year in which the "SERV-THRU-DATE" falls. Multiply each quantity by the corresponding rate. Sum the six results and wage index adjust this sum as described above, using the CBSA code in the "CBSA" field. The result is the wage index adjusted imputed cost for the period.

3.3. Subtract the outlier threshold from the imputed cost.

3.4. If the result determined in step 3.3 is greater than $0.00, calculate .80 times the result. This is the outlier payment amount.

3.5. Determine whether the outlier payment is subject to the 10% annual limitation on outliers as follows:

- Multiply the amount in the "PROV-PAYMENT-TOTAL" field by 10 percent to determine the HHA's outlier limitation amount.

- Deduct the amount in the "PROV-OUTLIER-PAY-TOTAL" from the outlier limitation amount. This result is the available outlier pool for the HHA.

- If the available outlier pool is greater than or equal to the outlier payment amount calculated in step 3.4, return the outlier payment amount in the "OUTLIER-PAYMENT" field. Add this amount to the total dollar amount resulting from HRG payment calculation. Return the sum in the "TOTAL-PAYMENT" field, with return code 01.

- If the available outlier pool is less than the outlier payment amount calculated in step 3.4, return no payment amount in the "OUTLIER-PAYMENT" field. Assign return code 02 to this record.

a. If the result determined in step 3.3 is less than or equal to $0.00, the total dollar amount resulting from all HRG payment calculations is the total payment. Return zeroes in the "OUTLIER-PAYMENT" field. Return

the HRG payment amount in the "TOTAL-PAYMENT" field, with return code 00.

4. Late-filed NOA payment penalty:

   4.1 If the value in "OVERRIDE-IND" is equal to Y, continue to step 5.

   4.2 If the span of days between the "FROM-DATE" and "RECEIPT-DATE" is greater than five and the value in"OVERRIDE-IND" is equal to N, reduce the "HRG-PAY" and "OUTLIER-PAYMENT" amounts by the span of days/30.

   4.3 Subtract the sum of the"HRG-PAY" and "OUTLIER-PAYMENT" amounts reduced by the late-filed NOA penalty from step 4.2 from the sum of the "HRG-PAY" and "OUTLIER-PAYMENT" amounts before the penalty. Return the result in "LATE-SUB-PENALTY-AMT." Continue to step 5.

5. Value-Based Purchasing Adjustment:

   Multiply all payment amounts by adjustment factor in "PROV-VBP-ADJ-FAC." Return the results as the final Medicare payment amounts in all appropriate output fields.

   Subtract the total payments calculated in steps 2 through 4 from the total VBP-adjusted payments calculated in step 5. Return the difference in the "VBP-ADJ-AMT" field.

70.5 - Annual Updates to the HH Pricer

(Rev. 10758; Issued: 05-11-21; Effective: 01-01-22; Implementation: 08-11-21)

Rate and weight information used by the HH Pricer is updated periodically, usually annually. Updates occur each January, to reflect the fact that HH PPS rates are effective for a calendar year. Updates may also occur at other points in the year when required by legislation. The following update items, when changed, are published in the Federal Register:

- The Federal standard period of care amount;
- The fixed loss amount to be used for outlier calculations;
- A table of case-mix weights and LUPA thresholds to be used for each HHRG;
- A table of national standardized per visit rates and per unit rates;

- The pre-floor, pre-reclassified hospital wage index; and
- Changes, if any, to the outlier loss-sharing percentage and the labor and nonlabor percentages.

Whenever these update items change, Medicare also publishes a Recurring Update Notification to inform providers and A/B MACs (HHH) about the changes. These Recurring Update Notifications also describe how the changes will be implemented through the HH Pricer.

80 – HH Grouper Program

(Rev. 11644, Issued: 10-13-22, Effective: 04-01-23, Implementation: 04-03-23)

The Home Health Resource Group (HHRG) used to pay home health services billed on TOB 032x are determined by the HH Grouper program. HHRGs are represented on claims in the form of HIPPS codes. Like the HH Pricer, the HH Grouper is a module within Medicare claims processing systems. The HHA sends a HIPPS code on the claim, using revenue code 0023. Medicare systems combine claim data and OASIS data and send the data to the HH Grouper to determine the HIPPS code used for payment. The HIPPS code from the Grouper replaces the provider-submitted HIPPS code on the claim and is then sent to the HH Pricer for payment calculations.

Medicare claims processing systems send an input record to Grouper for all claims and most adjustments. Medical review or other program integrity contractor adjustments are not sent to the Grouper. The Grouper returns an output record to the shared systems whenever an input record is sent.

No part of the Grouper logic is required to be incorporated into an HHA's billing system in order to bill Medicare, unless the HHA chooses to do so to assist their accounts receivable functions. The following is presented for A/B MACs (HHH) and as information for the HHAs, in order to help HHAs understand how their HH claims are processed.

80.1 – HH Grouper Input/Output Record Layout

(Rev. 11644, Issued: 10-13-22, Effective: 04-01-23, Implementation: 04-03-23)

The required data and format for the HH Grouper input/output record for periods of care beginning on or after January 1, 2020 are shown below:

File Position	Format	Title	Description
1 - 24	X(24)	Claim ID	Input item: Document control number of the claim record.
25-32	X(8)	From Date	Input item: The Statement Covers "From" date from the claim, in format CCYYMMDD

File Position	Format	Title	Description
33	9	Period Timing	Input item: Set to 1 when claim From date matches Admission date or when a CWF sequence edit is received. Otherwise, set to 2.
34 - 35	9(2)	Referral Source	Input item: If occurrence code 61 or 62 are present on the claim, the code value is moved to this field. The occurrence date is not moved.
36 - 42	X(8)	Principal Diagnosis	Input item: The principal diagnosis code from the claim.
43 - 50	X(8)	Secondary Diagnosis	Input item: The first secondary diagnosis code from the claim.
51 - 235	Defined above	Additional Secondary Diagnosis data	Input items: 23 additional occurrences of secondary diagnoses from the claim.
236-275	X(40)	Filler	For future use.
276	9	M1033-HOSP-RISK-HSTRY-FALLS	Input item: Moved from the M1033-HSTRY-FALL field on the QIES/OASIS screen in FISS. Valid values: 0,1
277	9	M1033-HOSP-RISK-WEIGHT-LOSS	Input item: Moved from the M1033-WEIGHT-LOSS field on the QIES/OASIS screen in FISS. Valid values: 0,1
278	9	M1033-HOSP-RISK-MLTPL-HOSPZTN	Input item: Moved from the M1033-MLTPL-HOSPZTN field on the QIES/OASIS screen in FISS. Valid values: 0,1
279	9	M1033-HOSP-RISK-MLTPL-ED-VISIT	Input item: Moved from the M1033-MLTPL-ED-VISIT field on the QIES/OASIS screen in FISS. Valid values: 0,1
280	9	M1033-HOSP-RISK-MNTL-BHV-DCLN	Input item: Moved from the M1033-MNTL-BHV-DCLN on the QIES/OASIS screen in FISS. Valid values: 0,1
281	9	M1033-HOSP-RISK-COMPLIANCE	Input item: Moved from the M1033-COMPLIANCE on the QIES/OASIS screen in FISS. Valid values: 0,1
282	9	M1033-HOSP-RISK-5PLUS-MDCTN	Input item: Moved from the M1033-5PLUS-MDCTN on the QIES/OASIS screen in FISS. Valid values: 0,1

File Position	Format	Title	Description
283	9	M1033-HOSP-RISK-CRNT-EXHSTN	Input item: Moved from the M1033-CRNT-EXHSTN on the QIES/OASIS screen in FISS. Valid values: 0,1
284	9	M1033-HOSP-RISK-OTHR-RISK	Input item: Moved from the M1033-OTHER-RISK on the QIES/OASIS screen in FISS. Valid values: 0,1
285	9	M1033-HOSP-RISK-NONE-ABOVE	Input item: Moved from the M1033-NONE-ABOVE on the QIES/OASIS screen in FISS. Valid values: 0,1
286-287	9(2)	M1800-CRNT-GROOMING	Input item: Moved from the M1800-CRNT-GROOMING on the QIES/OASIS screen in FISS. Valid values: 00,01, 02, 03
288-289	9(2)	M1810-CRNT-DRESS-UPPER	Input item: Moved from the M1810-DRESS-UPPER on the QIES/OASIS screen in FISS. Valid values: 00,01, 02, 03
290-291	9(2)	M1820-CRNT-DRESS-LOWER	Input item: Moved from the M1820-DRESS-LOWER on the QIES/OASIS screen in FISS. Valid values: 00,01, 02, 03
292-293	9(2)	M1830-CRNT-BATHG	Input item: Moved from the M1830-CRNT-BATHG on the QIES/OASIS screen in FISS. Valid values: 00,01, 02, 03, 04, 05, 06
294-295	9(2)	M1840-CRNT-TOILTG	Input item: Moved from the M1840-CRNT-TOILTG on the QIES/OASIS screen in FISS. Valid values: 00,01, 02, 03, 04
296-297	9(2)	M1850-CRNT-TRNSFRNG	Input item: Moved from the M1850-CRNT-TRNSFRNG on the QIES/OASIS screen in FISS. Valid values: 00,01, 02, 03, 04, 05
298-299	9(2)	M1860-CRNT-AMBLTN	Input item: Moved from the M1860-CRNT-AMBLTN on the QIES/OASIS screen in FISS. Valid values: 00,01, 02, 03, 04, 05, 06
300-599	X(301)	Filler	For future use.
601-607	X(7)	Version Used	Output item: The version of the HH Grouper which grouped the current claim. Informational only.

File Position	Format	Title	Description
608-612	X(5)	HIPPS Code	Output item: The HIPPS code determined by grouping the input items above. Moved to the HCPCS code field of revenue code 0023 line of the claim.
613-614	9(2)	Validity Flag	Output item: Beginning April 1, 2023, the specific diagnosis coding issue that requires a claim to be returned to the provider.
615-616	9(2)	Grouper Return Code	Output item: Identified technical issues that may cause no HIPPS code to be assigned.
617-700	X(84)	Filler	For future use.

If the return code is 05, the claim will be returned to the provider for correction because the principal diagnosis is not assigned to a clinical group.

If the return code is 03, the claim will be returned to the provider for correction because of a diagnosis coding issue that is indicated by the validity flag.

80.2 – HH Grouper Decision Logic and Updates

(Rev. 11644, Issued: 10-13-22, Effective: 04-01-23, Implementation: 04-03-23)

The HH Grouper decision logic, in the form of Java computer software, and related documentation are available to the public on the CMS website at:

www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/CaseMixGrouperSoftware.html.

The major release of the Home Health Grouper is January 1st each year with changes made as a result of the rulemaking process. There are two other off-cycle updates during the year for new and deleted ICD10-CM diagnosis codes. These are April 1st and October 1st each year. Whenever the HH Grouper is updated, Medicare also publishes a Recurring Update Notification to inform providers and A/B MACs (HHH) about the changes.

90 - Medical and Other Health Services Submitted Using Type of Bill 034x

(Rev. 10758; Issued: 05-11-21; Effective: 01-01-22; Implementation: 08-11-21)

HHAs may submit claims for certain medical and other health services which are paid from the Part B trust fund. The HHA may receive payment for these services outside of the prospective payment system (see Pub. 100-02, Medicare Benefit Policy Manual, chapter 7).

A. Patient Not Under A Home Health Plan Of Care

The HHA submits claims with TOB 034x to bill for certain "medical and other health services" when there is no home health plan of care. Specifically the HHA may bill using TOB 034x for the following services. (There must be a physician's certification on file.):

- Surgical dressings, splints, casts, and other devices used for reduction of fractures and dislocations. (See chapter 20 for billing enteral and parenteral supplies and equipment.)
- Rental or purchase of DME. (See chapter 20 for billing enteral and parenteral supplies and equipment.)
- Prosthetic devices. (See chapter 20 for billing enteral and parenteral supplies and equipment.)
- Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes.
- Outpatient physical therapy services. (See the Medicare Benefit Policy Manual, chapter 15 and the Medicare Claims Processing Manual, chapter 5.)
- Outpatient speech-language pathology services. (See the Medicare Benefit Policy Manual, chapter 15 and the Medicare Claims Processing Manual, chapter 5.)
- Outpatient occupational therapy services. (See the Medicare Benefit Policy Manual, chapter 15 and the Medicare Claims Processing Manual, chapter 5.)
- Diabetes Outpatient Self-Management Training (DSMT). (See the Medicare Benefit Policy Manual, chapter 15, section 300.5.1)
- Bone Mass Measurements. (See the Medicare Claims Processing Manual, chapter 13, section 140.)
- Smoking and Tobacco-Use Cessation Counseling Services. (See the Medicare Claims Processing Manual, chapter 32, section 12.)

Bills for services not under a home health plan of care should be submitted only after services are delivered. They should be submitted on a periodic basis, e.g., monthly, without regard to a period of care. These items are not reimbursed under HH PPS.

B. The Patient is Under a Home Health Plan of Care

If a patient is receiving home health services under a plan of care, the agency may bill for the following services on TOB 034x:

- A covered osteoporosis drug,
- Pneumococcal pneumonia, influenza virus, and hepatitis B vaccines, and
- Disposable negative pressure wound therapy services.

All other services are home health services and should be billed as an HH PPS period of care with Type of Bill 032x.

DME, orthotic, and prosthetics can be billed as a home health service using type of bill 032x or as a medical and other health service using type of bill 034x as appropriate. Alternately, these services may be provided to HH beneficiaries by a supplier. Refer to instructions in chapter 20 of this manual for submitting claims under arrangement with suppliers.

C Billing Spanning Two Calendar Years

The agency should not submit a medical and other health services bill paid from the Part B trust fund (TOB 034x only) for an inclusive period beginning in 1 calendar year and extending into the next. If the agency does not bill on a calendar month basis, it prepares two bills. The first covers the period ending December 31 of the old year; the second, the period beginning January 1 of the new year. This permits the A/B MAC (HHH) to apply the appropriate deductible for both years. HH PPS claims (TOB 032x) may span the calendar year since they represent 30-day periods of care.

D Billing For Laboratory Services

HHAs may provide laboratory services only if issued a CLIA number and/or having a CLIA certificate of waiver. HHAs do not report laboratory services, even when on the HH plan of care, to an A/B MAC (A) or (HHH) using an institutional claim format. These services are always billed to A/B MACs (B) using a professional claim format. To submit such claims, the HHA must have a CLIA number and a professional billing number. HHAs should contact the State Survey Agency to obtain a CLIA number. HHAs should contact the appropriate MAC to obtain a billing number. The survey process is used to validate that laboratory services in an HHA facility are being provided in accordance with the CLIA certificate.

90.1 - Osteoporosis Injections as HHA Benefit

(Rev. 10274, Issued: 08-07-2020, Effective: 01-01-2021, Implementation: 01-04-2021)

A. Billing Requirements

The administration of the drug is included in the charge for the skilled nursing visit billed using TOB 032x. The cost of the drug is billed using TOB 034x, using revenue code

0636. These drugs are paid on a reasonable cost basis, using the provider's submitted charges to make initial payments, which are subject to annual cost settlement.

Coverage requirements for osteoporosis drugs are found in Pub. 100-02, Medicare Benefit Policy Manual, chapter 7, section 50.4.3. Coverage requirements for the home health benefit in general are found in Pub. 100-02, Medicare Benefit Policy Manual, chapter 7, section 30.

Drugs that have the ingredient calcitonin are billed using HCPCS code J0630. HCPCS code J0630 is defined as up to 400 units. Therefore, the provider must calculate units for the bill as follows:

Units Furnished During Billing Period	Units of Service Entry on Bill
100-400	1
401-800	2
801-1200	3
1201-1600	4
1601-2000	5
2001-2400	6

Drugs that have the ingredient teriparatide may be billed using HCPCS code J3110, if all existing guidelines for coverage under the home health benefit are met. HCPCS code J3110 is defined as 10 mcg. Providers should report 1 unit for each 10 mcg dose provided during the billing period.

Drugs that have the ingredient denosumab are billed using HCPCS code J0897, if all existing guidelines for coverage under the home health benefit are met. HCPCS code J0897 is defined as 1 mg. Providers should report 1 unit for each 1 mg dose provided during the billing period.

Drugs that have the ingredients romosozumab-aqqg are billed using HCPCS code J3111, if all existing guidelines for coverage under the home health benefit are met. HCPCS code J311 is defined as 1 mg. Providers should report 1 unit for each 1 mg dose provided during the billing period.

Drugs that have the ingredient abaloparatide are billed using HCPCS code J3590 (unclassified biologics), if all existing guidelines for coverage under the home health benefit are met. As an unclassified code, HCPCS code J3590 does have not a standard definition for units. Providers should report 1 unit for each 80 mcg dose provided during the billing period.

All other osteoporosis drugs that are FDA approved and are awaiting a HCPCS code must use the miscellaneous code of J3490 until a specific HCPCS code is approved for use.

B. Edits

Medicare system edits require that the date of service on a 034x claim for covered osteoporosis drugs falls within the start and end dates of an existing home health PPS episode. Once the system ensures the service dates on the 034x claim fall within an HH PPS episode that is open for the beneficiary on CWF, CWF edits to assure that the provider number on the 034x claim matches the provider number on the episode file. This is to reflect that although the osteoporosis drug is paid separately from the HH PPS episode rate it is included in consolidated billing requirements (see §10.1.25 regarding consolidated billing).

Claims are also edited to assure that if the claim is an HH claim (TOB 034x), the beneficiary is female and that the diagnosis code for post-menopausal osteoporosis is present.

90.2 - Billing Instructions for Pneumococcal Pneumonia, Influenza Virus, and Hepatitis B Vaccines

(Rev. 1, 10-01-03)

Procedures for billing for pneumococcal pneumonia, influenza virus, and Hepatitis B Vaccines is covered in Chapter18.

90.3 – Billing Instructions for Disposable Negative Pressure Wound Therapy Services

(Rev. 12382; Issued: 11-28-23; Effective: 01-01-24; Implementation:01-02-24)

The instructions in this section apply to disposable negative pressure wound therapy (dNPWT) services provided during home health periods of care ending before January 1, 2024. Services provided during periods of care ending on or after January 1, 2024 are billed on Type of Bill 032x. See section 40.2 for billing instructions.

Effective January 1, 2017, Medicare makes a separate payment amount for a disposable negative pressure wound therapy (NPWT) device for a patient under a home health plan of care. Payment is equal to the amount of the payment that would otherwise be made under the Outpatient Prospective Payment System (OPPS).

Disposable NPWT services are billed using the following HCPCS codes:

- 97607 - Negative pressure wound therapy, (e.g., vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface

area less than or equal to 50 square centimeters.

- 97608 - Negative pressure wound therapy, (e.g., vacuum assisted drainage collection), utilizing disposable, non-durable medical equipment including provision of exudate management collection system, topical application(s), wound assessment, and instructions for ongoing care, per session; total wound(s) surface area greater than 50 square centimeters.

The HHA reports the HCPCS code with one of three revenue codes, depending on the practitioner that provided the service:

- Skilled nurse – 0559
- Physical therapist – 042x
- Occupational therapy – 043x.

When using revenue codes 042x or 043x, the HHA should not use the therapy plan of care modifiers (GO or GP) for NPWT services.

These HCPCS codes include payment for both performing the service and the disposable NPWT device, which is defined as an integrated system comprised of a nonmanual vacuum pump, a receptacle for collecting exudate, and dressings for the purposes of wound therapy. Services related to the provision of NPWT using a disposable device that do not encompass the provision of the entire integrated system should be billed per existing HH PPS guidelines.

To avoid duplication of payment, for instances where the sole purpose for an HHA visit is to perform NPWT using a disposable device, Medicare will not pay for a skilled nursing or therapy visit under the HH PPS. Rather, performing NPWT using a disposable device for a patient under a home health plan of care is be separately reimbursed the OPPS amount. In this situation, the HHA bills only under TOB 034x. This visit is not reported on the HH PPS claim (TOB 032x).

If NPWT using a disposable device is performed during the course of an otherwise covered home health visit (e.g., to perform a catheter change), the visit would be covered as normal. Performing NPWT using a disposable device will be separately reimbursed the OPPS amount. In this situation, the HHA bills under TOB 034X and this visit is also reported on the HH PPS claim (TOB 032x). The HHA must not include the time spent performing NPWT in their visit charge or in the length of time reported for the visit on the HH PPS claim.

100 - Temporary Suspension of Home Health Services

(Rev. 10758; Issued: 05-11-21; Effective: 01-01-22; Implementation: 08-11-21)

A physician may suspend visits for a time to determine whether the patient has recovered sufficiently to do without further home health services. When the suspension is temporary (does not extend beyond the end date of the 60-day certification period) and the physician later determines that the services must be resumed, the resumed services are paid as part of the same or subsequent 30-day period of care and under the same plan of care as before. The admission date remains the same on any claims. No special indication need be made on the claim(s) for the period of suspended services. Explanation of the suspension need be indicated only in the medical record.

If the suspension extends beyond the end of the current 60-day certification, HHAs must submit a discharge claim. Full payment will be due for the period of care. If the beneficiary resumes care, the HHA must establish a new plan of care and submit an NOA for a new admission.

110 - Billing and Payment Procedures Regarding Ownership and CMS Certification Numbers (CCNs)

(Rev. 2977, Issued; 06-20-14, Effective: 09-23-14; ICD-10: Upon Implementation of ICD-10, Implementation: 09-23-14; ICD-10: Upon Implementation of ICD-10)

110.1 – RESERVED

(Rev. 4378, Issued: 08-23-19, Effective: 01-01-20, Implementation: 11- 27-19)

110.2 - Payment Procedures for Terminated HHAs

(Rev. 10758; Issued: 05-11-21; Effective: 01-01-22; Implementation: 08-11-21)

Medicare regulations allow that payment may be made for home health services for up to thirty days after a home health agency (HHA) terminates their Medicare provider agreement. This payment may be made if the home health services are furnished under a home health plan of care established before the effective date of the termination.

Medicare continues to make full period of care payments for periods which extend beyond a provider's termination date if the home health services are provided under a plan of care established prior to that date and if the home health period of care ends within the 30 day period.

Transmittals Issued for this Chapter

Rev #	Issue Date	Subject	Impl Date	CR#
R12382CP		Separate Payment for Disposable Negative Pressure Wound Therapy Devices on Home Health Prospective Payment System Claims	01/02/2024	13244
R12291CP	10/05/2023	Separate Payment for Disposable Negative Pressure Wound Therapy Devices on Home Health Prospective Payment System Claims No Longer Sensitive - Rescinded and Replaced by Transmittal 12382	01/02/2024	13244
	07/20/2023	Separate Payment for Disposable Negative Pressure Wound Therapy Devices on Home Health Prospective Payment System Claims SENSITIVE CONTROVERSIAL DO NOT POST– Rescinded and Replaced by Transmittal 12291	01/02/2024	13244
R12106CP	06/29/2023	Corrections to Home Health Processing - Claims with Condition DR or Claims Receiving Admission Source Edits	01/02/2024	13225
R11796CP	01/19/2023	Revisions to Processing of Home Health Disaster Related Claims and Contractor-Initiated Adjustments	04/03/2023	13020
R11644CP	10/13/2022	Home Health Claims - New Grouper Return Code Edits and Informational Unsolicited Response	04/03/2023	12924
R11634CP	10/06/2022	Home Health Claims - New Grouper Return Code Edits and Informational Unsolicited Response- Rescinded and replaced by transmittal 11644	04/03/2023	12924
R11341CP	04/07/2022	Corrections to Home Health Billing for Denial Notices and Calculation of 60-Day Gaps in Services	10/03/2022	12657
R10987CP	09/10/2021	Home Health Notices of Admission -- Additional Manual Instructions	11/10/2021	12424

R10919CP	08/06/2021	Low Utilization Payment Adjustment (LUPA) Add-on Amounts for Home Health (HH) Occupational Therapy Visits and Corrections to Payment Grouping Processes	01/03/2022	12315
R10839CP	06/09/2021	Replacing Home Health Requests for Anticipated Payment (RAPs) with a Notice of Admission (NOA) -- Manual Instructions	08/11/2021	12256
R10758CP	05/11/2021	Replacing Home Health Requests for Anticipated Payment (RAPs) with a Notice of Admission (NOA) -- Manual Instructions Rescinded and replaced by transmittal 10839	08/11/2021	12256
R10696CP	03/31/2021	Penalty for Delayed Request for Anticipated Payment (RAP) Submission – Implementation	01/04/2021	11855
R10403CP	10/27/2020	Penalty for Delayed Request for Anticipated Payment (RAP) Submission – Implementation- Rescinded and replaced by transmittal 10696	01/04/2021	11855
R10369CP	09/24/2020	Penalty for Delayed Request for Anticipated Payment (RAP) Submission – Implementation- Rescinded and replaced by transmittal 10403	01/04/2021	11855
R10274CP	08/07/2020	Update to Osteoporosis Drug Codes Billable on Home Health Claims	01/04/2021	11846
R10254CP	07/31/2020	Penalty for Delayed Request for Anticipated Payment (RAP) Submission – Implementation- Rescinded and replaced by transmittal 10369	01/04/2021	11855
R4489CP	01/09/2020	Home Health (HH) Patient-Driven Groupings Model (PDGM) - Split Implementation	07/01/2019	11081
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